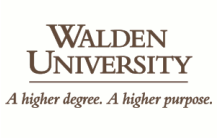

2016

Job Satisfaction, Organizational Culture, and British Nurses' Intention to Leave Employment

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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2016

Abstract

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by

Brendan Edward Williams

MBA, Rensselaer Polytechnic Institute, 1981

BA, University of Connecticut, 1978

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Walden University

January 2016

Abstract

In spite of decades of research, concerning nurse's intention to leave their employer (ITL), in 2011, 31.2% of the British nurses surveyed indicated they had formed an ITL. Grounded in reasoned action theory as developed by Ajzen and Fishbein, the purpose of the correlational study was to provide hospital managers with information regarding the relationship among nurse's job satisfaction (JS), organizational culture (OC), and ITL. The archival data from the 2011 NHS Staff Survey included responses from nurses (n = 21,257) across the British National Health Service. The Spearman's rho correlates r_s (21,257) indicated relationships among nurse's job satisfaction, organizational culture, and ITL. Among nurse's considering leaving their employer, the findings were statistically significant ($p < .01$) with a large effect size (-.534) for JS and medium effect size (-.345) for OC. With the ITL benchmark of planning to leave in 12 months, the findings were significant ($p < .01$) with medium effect size (-.495) for JS and medium effect size (-.321) for OC. Among nurses who intended to leave as soon as they had another job the significant results ($p < .01$) had a large effect size for JS (-.525) and medium effect size (-.340) for OC. As nurses form ITL, they might participate in work avoidance behaviors such as increased absenteeism. The study findings and the instruments used in this study may identify areas for improvement as pathways to manage the costs associated with turnover and absenteeism. Furthermore, reducing turnover and absenteeism might contribute to social change. Reducing turnover and absenteeism might improve the quality of care provided to patients. Addressing the factors that might contribute to ITL may also improve the quality of life for nurses.

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I am grateful for the support and guidance of the people who have worked with me to reach this stage in my journey as a lifelong learner. Dr. Edward “Ed” Paluch stepped in as chair to fill a void left when my original chair left the program. The transition was seamless with the weekly contact in the DDBA 9000 discussions. Ed contributed to my progress with timely, academically rigorous, and succinct feedback. As the second committee member, Dr. Kenneth “Dr. G” Gossett provided the third perspective necessary to explore alternative perspectives. Drawing upon the DBA Studies that Dr. G had participated in was instrumental in adding context to the rubric. Both shared their time, content knowledge, and academic tone at each step of the process. Dr. Roger Mayer completed the duties of URR while supporting the efforts of the other participants. Along the way, my entire committee provided feedback to improve the academic rigor and pointed out errors my eyes missed. I was fortunate to have this team for my committee.

Thank you to my family members who tolerated my divided attention yet never failed to provide the right balance of support and encouragement. From debates regarding the merits of a statistical test, word choices, to come on we are going to jump out a good airplane, they were there beside me. I am grateful for the enthusiastic support of collogues, friends, and clients.

As an archival researcher, I thank the stakeholders who provided the study data. NHS employees completed the 2011 NHS Staff Survey and thereby agreed to share the results with researchers. Staff with the Picker Institute Europe gathered, coded, archived,

and provided the access points for the database. The British Government provided the funding to conduct 2011 NHS Staff Survey and established the transparency behind releasing the data to researchers.

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Section 1: Foundation of the Study

Rebuilding from the devastations of World War II, the British government established the National Health Service (NHS) to provide health care services (Sparer, France, & Clinton, 2011). For decades, the NHS operated as a closed system with patients assigned to local providers. Following a series of high-profile episodes of substandard care and fiscal constraints, the Thatcher government introduced reforms that transformed the NHS into a competitive model with incentives for managing revenue and resources (Bevan & Wilson, 2013). The changes led to management development programs from the board level to front line managers (Edmonstone, 2013a). However, the management development programs placed emphasis on leadership competency rather than developing leadership capability (Edmonstone, 2013b).

Background of the Problem

Legislative changes provided opportunities for local governance and incentives for returning a profit (Beckert, Christensen, & Collyer, 2012; Propper, 2012). In the competitive NHS market, hospitals can increase revenue by providing quality care (Lunt, Mannion, & Exworthy, 2013; Victoor, Delnoij, Friele, & Rademakers, 2012). The level care provided by nurses is the basis for providing quality care that might lead to improved health outcomes and increased patient satisfaction (Kohlbrenner, Whitelaw, & Cannaday, 2011), which might result in increased revenue. To maintain a sufficient number of the NHS nurses needed to maintain the desired levels of care, managers must improve employee retention rates (Buchan, & Seccombe, 2012).

Within the NHS, patients receive tertiary care at acute care/specialty trusts (acute care trusts). Acute care trusts provide analogous services to acute care hospitals (hospitals). Hospitals are complex organizations that are difficult to manage due to linkages between cost control, quality care, and patient safety (Aubry, Richer, & Lavoie-Tremblay, 2013). Among the multiple pathways for managing costs, quality care, and patient safety, I examined nurses' intention to leave employment (ITL). As documented in the following sections, ITL increased costs (Alperovitch-Najenson, Treger, & Kalichman, 2014; Hom, Mitchell, Lee, & Griffith, 2012) and impaired the quality pathway (Dixon-Woods, Minion, Mckee, Willars, & Graham, 2014) that supported revenue. In addition, ITL was associated with decreased quality of life for patients (Hayes et al., 2012) and nurses (Lu, Barriball, Zhang, & While, 2012). The background established the context of the study; the following sections add focus to the examination of the ITL problem confronting NHS managers.

Problem Statement

Nurses' increased ITL weakens managers' ability to reduce labor costs, due to increased absenteeism and increased turnover (Hom et al., 2012). Among U.K. NHS nurses, 44 % indicated ITL in surveys conducted in 2010 (Aiken et al., 2012). Increased job satisfaction decreased ITL (Han & Jekel, 2011). An organizational culture based on a combination of leadership, communication, and managing violence fostered a lower ITL (Brown, Fraser, Wong, Muise, & Cummings, 2013). The general business problem is that some hospital managers are unable to control ITL, which negatively affects financial performance (Everhart, Neff, Al-Amin, Nogle, & Weech-Maldonado, 2013). The specific

business problem is that some acute care hospital managers do not understand the relationship among job satisfaction, organizational culture, and nurses' ITL, and this gap in their knowledge might diminish managers' ability to reduce labor costs.

Purpose Statement

The purpose of the quantitative correlational study was to examine the relationship among acute cares nurse's job satisfaction, organizational culture, and ITL. The predictor variables are nurse's job satisfaction and organizational culture. The dependent variable was nurse's ITL. I used secondary data from the population of 163 acute care NHS England (NHS) Trusts as measured by the 2011 NHS Staff Survey. The 2011 NHS Staff Survey is the most recent survey that included measures of ITL. The results of a better understanding of the correlates from this study may provide opportunities for positive social change for patients and nurses.

Reduced ITL might lessen medical errors and could improve the quality of life for nurses. As nurses develop ITL, they might deliberately avoid communications (Hom et al., 2012). Communication is critical for preventing health care errors (Brunetto et al., 2013). Likewise, nurses with higher levels of ITL could have higher absenteeism rates (Hom et al., 2012). Increased absenteeism resulted in nurses working longer shifts. Nurses who worked additional hours reported a decreased quality of life (Boamah & Laschinger, 2015; Lu et al., 2012).

Nature of the Study

This study using a quantitative method was an examination of secondary data from the 2011 NHS Staff Survey. High-quality secondary data provided researchers with

unprecedented options for using quantitative methods to examine the associations between different phenomena in the workplace (Charlwood et al., 2014). The NHS Staff Survey conducted in 2009, surveyed nurses (n = 17,707) from the population of 163 acute trusts provided a robust source of data for researching ITL (Carter & Tourangeau, 2012). Tillman, Clemence, and Stevens (2011) suggested using quantitative methods might produce better validity, generalizability, and reliability. Conducting a study using qualitative methods is not suitable for research on this scale. As noted by Tillman et al. (2011), a typical sample size for qualitative studies is between three and 20 participants. Within the quantitative method, the design options include experimental, quasi-experimental, and correlational designs.

I applied a correlational design to examine the relationships, if any, between the predictor variables job satisfaction and organizational culture with the dependent variable ITL. Published literature reviews confirmed that correlational design is consistent with the extant research regarding ITL (Chan, Tam, Lung, Wong, & Chau, 2013; Hayes et al., 2012). Quantitative correlational studies were the dominant analytical mindset for employment intentions (Allen, Hancock, Vardaman, & Mckee, 2014). My literature review contains other examples of correlational studies with the predictor variables and ITL. In addition, experimental and quasi-experimental designs might violate ethical research guidelines for human subjects. Exposing study participants to harm might violate research ethics (McDonald & Patka, 2012). Nurses exposed to bullying reported symptoms of post traumatic stress disorder (Laschinger & Nosko, 2013). Managers' response to bullying is one of the measures of organizational culture. A study that

included withholding treatment in terms of response to bullying might expose participants to psychological harm.

Research Question

The overarching research question based on data from a survey of U.K. acute care nurses (nurses) is as follows: What is the relationship among job satisfaction, organizational culture, and nurse's intention to leave employment? Three sub questions support the examination of the predictor variables and the urgency of the dependent variable intent to leave employment.

RQ 1: What is the relationship among nurse's job satisfaction, organizational culture, and a nurse thinking about leaving their employer?

RQ 2: What is the relationship among nurse's job satisfaction, organizational culture, and a nurse planning a job search within the next 12 months?

RQ 3: What is the relationship among nurse's job satisfaction, organizational culture, and a nurse planning to leave as soon as they find another job?

Hypotheses

$H1_0$: There is no significant relationship among nurse's job satisfaction, organizational culture, and a nurse thinking about leaving their employer.

$H1_a$: There is a significant relationship among nurse's job satisfaction, organizational culture, and a nurse thinking about leaving their employer.

$H2_0$: There is no significant relationship among nurse's job satisfaction, organizational culture, and a nurse planning a job search within the next 12 months.

$H2_a$: There is a significant relationship among nurse's job satisfaction, organizational culture, and a nurse planning a job search within the next 12 months.

$H3_0$: There is no significant relationship among nurse's job satisfaction, organizational culture, and a nurse planning to leave as soon as they find another job.

$H3_a$: There is a significant relationship among nurse's job satisfaction, organizational culture, and a nurse planning to leave as soon as they find another job.

Theoretical Framework

The dependent variable for the study is a nurse's ITL. Forming employment intentions is a complex decision process (Brewer, Kovner, Greene, Tukov-Shuser, & Djukic, 2012). The theoretical framework, the reasoned action theory proposed by Ajzen and Fishbein in 1975 and modified in 1980, is a model for evaluating complex decisions (Prestholdt, Lane, & Mathews, 1987). The theoretical framework provides a map that guides researchers while providing a conceptual lens (Evans, Coon, & Ume, 2011). I selected reasoned action theory as the lens for my examination of ITL. The following is a summary of the theory.

According to the reasoned action theory, intentions are indicators of motivational levels (Ajzen & Fishbein, 1980). Higher levels of intention for a behavior reflect that someone will endeavor to exhibit that behavior (Ajzen & Fishbein, 1980). However, Ajzen and Fishbein (1980) postulated the behavior would only occur if the individual has control over the process. Within the reasoned action theory, when intentions and control coincide there is a direct prediction of the behavior (Ajzen & Fishbein, 1980). The extant

literature supported the reasoned action theory as an appropriate theoretical framework as summarized briefly in the following.

The development of the reasoned action theory established the foundation for examining withdrawal states as a formative stage of ITL (Bergman, Payne, & Boswell, 2012). Applying reasoned action theory provided hospital managers with an operational method for attempting to control turnover (Prestholdt et al., 1987). The conceptual breath of reasoned action theory is an advantage for researchers (Liou, 2009). In the 21st century, reasoned action theory provided the framework for two conceptual models of nursing turnover (Hom et al., 2012; Tourangeau, Cummings, Cranley, Ferron, and Harvey, 2010).

Operational Definitions

Defensive silence: When an individual intentionally remains silent to shield themselves from consequences of their behaviors (Kim, Kang, Kim, & You, 2014).

Intention to leave: The preference held by a current employee to resign from their current position (Asegid, Belachew, & Yimam, 2014).

Job satisfaction: How much employees like their work (Price & Mueller, 1981).

Organizational climate: An employee's perception of organizational culture (Karassavidou, Glaveli, & Zafiropoulos, 2011)

Organizational culture: A reflection of how employees accomplish their work tasks within an organization (Karassavidou et al., 2011).

Assumptions, Limitations, and Delimitations

Research is subject assumptions, limitations, and delimitations. Disclosing assumptions facilitated judging the quality of the study (Leedy & Ormrod, 2009). The evaluation of the self-reported limitations is an integral part of evaluating studies submitted for publication (Brutus, Aguinis, & Wassmer, 2013). The following subsection is the discussion of the assumptions, limitations, and delimitations of the study. I begin each subheading with the operational definition of the respective term.

Assumptions

Assumptions are the self-evident truths that constitute the foundation for the research (Leedy & Ormrod, 2009). An integral challenge regarding secondary data is the questions asked might not reflect the wording from validated instruments (Greenhoot & Dowsett, 2012). To mitigate the risks from different wording, I researched the origin of the instruments used to develop the NHS Staff Survey. When questions did not align precisely, thoughtful evaluations might increase the validity and reliability from the surveys (Tellez, 2012). For the questions that were not verbatim from other instruments, I assumed there are no material errors in measuring the constructs. Additional assumptions arose from using surveys.

I assumed the NHS employees who completed the survey understood the questions and provided honest responses. The NHS Staff Survey protocol contained a mitigation strategy for understanding the questions and honesty. The supporting documents provided to potential respondents included a toll-free number questions/concerns (Care Quality Commission and Picker Institute Europe, 2013).

However, I found no information regarding nurses calling the toll-free number. Respondents valued privacy while completing surveys (Atinga, Domfeh, Kayi, Abuosi, & Dzansi, 2013).

The survey process included four mechanisms to protect the identity of the respondent to encourage honest responses. First, only the contractor had access to the raw data. Second, the contractor removed all identifying information the data prior to release to the employer/public access. Third, the contractor mailed surveys to the potential respondents (Admasachew & Dawson, 2011). Allowing participants to complete surveys in the privacy of their home is appropriate for sensitive questions involving interacting with colleagues and managers (Atinga et al., 2013). Finally, the contractor did not release responses for particular questions until 11 individuals responded to that question. Nevertheless, Farrell and Shafiei (2012) found nurses were reluctant to answer to blind surveys regarding workplace violence fearing retaliation from supervisors. I addressed cleaning the data of missing responses in Section 2.

Limitations

Study limitations reveal the weaknesses inherent to the design of the study (Gelo, Braakmann, & Benetka, 2008).). Researchers should place the study limitations in order and disclose the salient limitations (Brutus et al., 2013). As noted by Glambek, Matthiesen, Hetland, and Einarsen (2014), time gaps between gathering data and data analysis might limit the application of the study findings to current conditions. While the NHS Staff Survey questions in 2011 aligned with the study dependent variables, the time

lag is a limitation. The 2011 NHS Staff Survey is the most recent survey that included questions regarding intention to leave employment.

Another limitation is that the format of NHS Staff Survey restricted the options for employees to share additional information The NHS Staff Survey did not permit open-ended responses. Questions included measures from employees who were targets of harassment/violence. However, employees who witnessed harassment/violence developed similar attitudes toward their working conditions as targets (Hogh, Hoel, & Carneiro, 2011; Longo, 2013). As a result, the NHS Staff Survey might not reflect ITL formed by witnesses.

The distribution protocol for the archival data created another limitation. Chiang and Chang (2012) found significant relationships among age, marital status, job tenure, and ITL for Taiwanese nurses (n =314). To protect the anonymity of respondents, the data file did not include demographic information. Therefore, I could not examine the possible relationships between age, marital status, job tenure, and ITL.

Jha and Epstein (2013) noted that using surveys produced the limitation of nonresponse bias. The response rate for the 2011 survey was 53%. This response rate compares to response rate of 43% in a study Dutch health care workers (Biron & Boon, 2013), 64% of nurses from three Italian hospitals (Galletta, Portoghese, Penna, Battistelli, & Saiani, 2011), and 83% response rate with Australian nurses (Duffield, Roche, Blay, & Stasa, 2011).

The 2011 NHS Staff Survey coincided with a period of rising unemployment. In the U.K., the national unemployment rate increased from 2007 to 2011 similar to the

average rates for all Organisation for Economic Co-operation and Development countries (Buchan, O'May, & Dussault, 2013). The British government imposed barriers to entry for migrant nurses from countries outside of the European Unions (Buchan et al., 2013). For this reason, employees had limited opportunities to turnover (Price & Mueller, 1981). Employees who desire turnover but have limited options are trapped stayers who maintain a level of ITL (Hom et al., 2012). A limitation of this study is that based on the NHS Staff Survey data, I could not distinguish between ITL held by trapped stayers and nurses with newly formed ITL.

Delimitations

Delimitations designate the boundaries of the study. Delimitations are the areas not included within the purpose of the study (Leedy & Ormrod, 2009). The NHS Staff Survey included the population of all Trusts from across the UK (Woodrow & Guest, 2012), in so doing limiting the generalizability of the study beyond the U.K. However, hospital ITL researchers included results from similar cultural/organizational settings (Duffield et al., 2011, Galletta et al., 2011, Heinen et al., 2013, Laschinger & Fida, 2014). Employers in the United States and Europe might experience similar employee turnover consequences due to comparable labor costs (Hancock, Allen, Bosco, McDaniel, & Pierce, 2011).

The employee's occupation moderated the decision to leave or to stay (Nanncarrow, Bradbury, Pit, & Ariss, 2014). Limiting the study to hospital nurses may restrict the generalizability to other professions. I delimited the data to nurses employed by acute care trusts. The study findings might not apply to nurses outside of acute care.

Nurses in long-term care experienced a different work environment in comparison to acute care nurses, which changed the factors leading to the formation of intentions to remain employed (McGilton, Tourangeau, Kavcic, & Wodchis, 2013).

Significance of the Study

Perkins (1939) identified turnover as the second most important indicator in evaluating a hospital's nursing service, and researchers continued to evaluate evolving turnover models (Gilmartin, 2013). The significance of the study relates to two domains of influence. First, conducting research that might contribute to business success is an underlying theme of Doctor of Business Administration programs (Banerjee & Morley, 2013). Contributing to business success is consistent with the recommendation by Markides (2011) for researchers to consider the perspective of practitioners and to deliver research that practitioners can apply. Moreover, research conducted while earning a graduate degree granted by Walden University must also support Walden's core mission of positive social change (Salter, 2013). The examination of the relationships, if any, among job satisfaction, organizational culture, and intention to leave may well have significance to business practitioners and will possibly lead to positive social change.

Contribution to Business Practice

In the 21st century, theorists noted the business implications arising out of the precursors of turnover led directly to negative consequences from increased costs and missed opportunities to increase revenue. Researchers discussed the financial implications of turnover as justification for reducing the intention to leave with examples drawn from multiple countries (Duffield, Roche, Homer, Buchan, & Dimitrelis, 2014).

Providing managers with the information that might allow them to intervene in turnover plans could reduce turnover costs. Based on 2010 data, the direct and indirect costs of replacing each Australian hospital nurse could be as high as $104,686 (Approximately $75,700 U. S.; Roche, Duffield, Homer, & Buchan, 2014). Increased costs might also occur prior to actual turnover.

Hom et al. (2012) indicated that as employees developed an ITL, they may engage in increased work avoidance behaviors (WAB) as well as increased counterproductive work behaviors (CWB).

According to Alperovitch-Najenson et al. (2014), manifestations of work avoidance behavior included absenteeism and extended injury recovery time. Both absenteeism and extended injury recovery time may contribute to increased labor costs. To cover shifts, hospital managers might have to pay overtime wages to fill the positions. Other examples of work avoidance behavior included refusal of additional shifts, reduced teamwork, and aligning their effort to minimally acceptable levels (Estes, 2013). Lost workdays by employees exposed to workplace bullying exceeded the average number of lost workdays by 92% (Ortega, Christensen, Rugulies, & Borg, 2011). According to Ortega et al. (2011), U.K. employees impacted by workplace bullying missed 18 million workdays annually. Another source of increased costs is replacing stolen property. Christian and Ellis (2014) established a relationship between higher levels of ITL and increased deviant organizational behaviors such as theft of company property.

NHS reforms permitted competition that allowed trusts to increase revenue by competing for elective procedures (Bevan & Wilson, 2013). Patients relied on customer

service reports when selecting a hospital for elective services (Lunt et al., 2013). Service employees who have reached higher levels of ITL might withhold efforts resulting in diminished customer satisfaction and may prompt other employees to consider leaving the organization (Kumar, Dass, & Topaloglu, 2014). Reducing work avoidance behavior and counterproductive workplace behaviors is also consistent with opportunities for positive social change.

Implications for Social Change

Hospitals have multiple stakeholders (Montgomery, Todorova, Baban, & Panagopoulou, 2013). Improving the quality of life for patients and employees is a potential area for realizing positive social change. In turn, the families/friends of these stakeholders are secondary beneficiaries. The study findings might encourage managers to reduce the behaviors associated with substandard levels of care and decrease negative workplace behaviors that increase ITL as well as interfering with an employee's mental health.

A positive culture is a foundation for providing the expected level of care within the NHS (West & Dawson, 2012). The history of the NHS culture revealed bullying as an ongoing concern (Pope & Burnes, 2013). A bullying culture could exist at the unit or institutional level (Barber, 2012). Gallagher (2012) added the fact that bullying interfered with employee concentration that might cause a distraction, and in so doing contribute to lapses in patient safety/quality of care. If the study findings encourage managers to address the NHS bullying culture as a pathway for reducing ITL, this may well improve the quality of care. Study results from the evaluation of NHS Staff surveys and patient

satisfaction surveys indicated a relationship between employees who considered leaving employment and decreased perceptions of care (Dawson, 2007; West & Dawson, 2012). The literature also established linkages between reducing the bullying culture and health care workers' quality of life.

A study of nurses in Tehran revealed reports of diminished self-worth in support of the conclusion that bullying might reduce a nurse's dignity (Khademi, Mohammadi, & Vanaki, 2012). A summary of the effects of bullying on a nurse's quality of life included anxiety, depression, posttraumatic stress disorder, and suicide (Wilson, Diedrich, Phelps, & Choi, 2011). The psychological repercussions of bullying were similar the responses by nurses to who experienced increased job demands (Adriaenssens, De Gucht, & Maes, 2013). Nurses with an ITL might respond with increased absenteeism and other work avoidance behaviors (Hom et al., 2012) which in turn may increase the job demands of the remaining nursing staff.

A Review of the Professional and Academic Literature

My intention for the literature review is to situate this research in the extant literature. The purpose of the quantitative, correlational study is an examination of the relationship among acute cares nurse's job satisfaction, organizational culture, and ITL. The hypothesis sets I used for my study were as follows:

$H1_0$: There is no significant relationship among nurse's job satisfaction, organizational culture, and a nurse thinking about leaving their employer.

$H1_a$: There is a significant relationship among nurse's job satisfaction, organizational culture, and a nurse thinking about leaving their employer.

$H2_0$: There is no significant relationship among nurse's job satisfaction, organizational culture, and a nurse planning a job search within the next 12 months.

$H2_a$: There is a significant relationship among nurse's job satisfaction, organizational culture, and a nurse planning a job search within the next 12 months.

$H3_0$: There is no significant relationship among nurse's job satisfaction, organizational culture, and a nurse planning to leave as soon as they find another job.

$H3_a$: There is a significant relationship among nurse's job satisfaction, organizational culture, and a nurse planning to leave as soon as they find another job.

I have arranged the literature review in seven thematic subsections. The first theme is a review of the history of the U.K. NHS to document the legislative changes in the 21st century. Because of these changes, NHS managers encountered business problems and opportunities similar to managers in other competition based health care systems. The next five themes aligned with traditional subsections of the literature reviews including (a) the theoretical framework of reasoned action and four models of nurses' continued employment (b) the first predictor variable, job satisfaction (c) the second predictor variable, organizational culture, (d) the implications of managing the dependent variable, ITL, and (e) methodologies and design. The final subsection is a review of the literature regarding secondary research to position the use of the 2011 NHS Staff Survey data. Each subsection begins with an overview of the content and format for that subsection.

The search process included the literature from multiple academic libraries. I have access to the Walden Library, Homer Babbidge Library at the University of Connecticut,

and two other college libraries. Google Scholar permitted simultaneous searches of all of these library collections. Key search terms included Boolean phrases such as *intention to leave, intention to stay, organizational culture, safety climate, leader-member exchange, job satisfaction,* and *avoidant leadership*. ITL is not the direct inverse of intention to stay (Nanncarrow et al., 2014). However, including literature for both intentions is meaningful for researchers concerned with retaining nurses (Chan et al., 2013; Cowden, Cummings, & Profetto-McGrath, 2011).

An advantage of using Google Scholar was improved access to collections and simultaneous search of multiple indexes (McFadden, Taylor, Campbell, & McQuilkin, 2012). A sample of the indexes from my searches included ABI/Inform, Ebsco Host, PyscInfo, Public Library of Science, PubMed Central, Sage Complete, and Taylor & Francis. Decreased sensitivity was a weakness of using Google Scholar searches (McFadden et al., 2012). Google Scholar searches did not support a filter for refereed journals. For that reason, I maintained an Excel file to document refereed status and pagination rules for the 479 journals I identified in my searches. According to Ulrich's, refereed status applied to 425 of the journals. Within the literature review, I synthesized the information from 160 sources. Among these sources, 98% appeared in refereed journals. The publication dates are within 5 years of the anticipated approval by the Chief Academic Officer for 92% of the sources. I supplemented the key terms searches with four methods.

The first method was consideration of the publishers' recommendations of similar articles. Next, I considered the articles cited within the primary search articles. I also

refined the primary searches using additional keywords from the articles I reviewed. The last method of expanding my search included a review of articles that cited the primary article. The rationale for opening the review of the literature with the history of the NHS was to confirm the NHS operated as a competitive market in which managers experienced financial consequences for their management decisions.

NHS History and Transition to a Business Model

Residents of the United Kingdom (U.K.) receive health care services from the NHS. My objectives for this section of the literature review were threefold. The first was to provide a brief history of the NHS. The second objective was to document the business challenges/opportunities created by a series of reforms commencing in the 1990s that moved the NHS to a model in which hospitals compete for patients and revenue. One of the NHS reforms led to increased transparency, which resulted in public access to the NHS Staff Survey (Alvarez, Canduela, & Raeside, 2012). My third objective was to introduce the NHS Staff Survey. I summarized the application of the NHS Staff Survey as a source of data in the secondary data section of the review of professional and academic literature. The three subcategories of this section of the literature review are (a) history of the NHS, (b) competition and case-based payment system, and (c) NHS Staff Survey as the basis/inspiration for research.

History of the NHS. The ravages of World War II provided the need and opportunity to rebuild the infrastructure of the U.K. health care system. In the 1940s, the NHS system that developed in the United Kingdom was one of the most centralized providers of health care services (Sparer et al., 2011). Centralized control was consistent

with the goals of the individuals who designed the NHS. According to Sparer et al. (2011), the first minister of the NHS held the opinion that localized control over health care would result in an unequal delivery of services; therefore, a centralized system was necessary to provide equivalent services across the NHS. Sparer et al. summarized a period of increased centralization, which included a series of reforms that compressed the continuum of health care providers. The initial reforms brought (a) primary physicians, (b) health centers, (c) acute care, and (d) nursing services under the control of regional health authorities (Sparer et al., 2011).

The NHS developed into the largest provider of health services in the world funded with public funds (Baluch, Salge, & Piening, 2013). The initial NHS model restricted consumer choice at the trust level. Permanent U.K. residents obtained health care services from the providers assigned to their region (Lunt et al., 2013). Individuals received care in public hospitals at no out of pocket cost due to public funding (Propper, 2012). A series of high-profile lapses in quality transpired at the close of the 20th century leading to public and political attention regarding the operations of the NHS.

At the Bristol Royal Infirmary, cardiologists performed open-heart surgery on pediatric patients in spite of the known increased risk of death (Dodds & Kodate, 2011). Contrary to the anonymous patient deaths from medical errors noted in *To Err is Human*, the deceased children in the United Kingdom had advocates. The grieving parents provided a voice for their departed offspring that prompted an inquest, which galvanized the press, regulators, politicians, and U.K. citizenry. As noted by Saunders (2013) the 30 to 35 deaths over a 4-year period were a failure at the individual level and a system-wide

failure. Nearly a decade later, 400 to 1,200 patients died due to inferior care provided at the Mid Staffordshire Foundation Trust (Newdick & Danbury, 2013). Newdick and Danbury (2013) renewed the appeal for researchers to study culture within the NHS as a path to improving the outcomes of care. A series of reforms occurred that devolved control to local boards and provided financial incentives for hospital managers.

Competition and reimbursement reform. The 1991 NHS Community Care Act established semiautonomous local boards for NHS Trusts that are analogous to corporate boards (Kirkpatrick, Bullinger, Lega, & Dent, 2013). According to Bevan and Wilson (2013), the Thatcher government implemented a shift in the NHS from a model based on trust and altruism model to the choice and competition model. By 2008, patients had choices for elective services and internet access to quality metrics drove competition for hospital services in the United Kingdom. (Cooper, Gibbons, Jones, & McGuire, 2011). In a competitive market, increased revenue followed changes in behavior that resulted in outcomes desired by consumers (Greener, 2012). Lunt et al. (2013) noted the importance of quality care when U.K. residents selected their provider for elective services. Hospitals known for high-quality care in conjunction with an overall superior reputation might entice patients to travel to obtain care (Al-Amin, Makarem, & Pradhan, 2011).

The reforms also contained incentives for efficiency and cost control. Reforms led to the authorization of private ownership of hospitals and established a two-tier system with Trusts and Foundation Trusts (Cooper et al., 2011). Following the reforms in the late 20th century, administrators employed by a Foundation Trust had incentives to return a profit (Beckert et al., 2012, Propper, 2012). Attainting Foundation Trust status permitted

managers to retain financial surpluses to fund additional services or to fund system improvements (Beckert et al. 2012). After the reforms, board-level leaders of U.K. hospitals devoted more attention to improving quality than board-level leaders in the United States (Jha & Epstein, 2013). Reforms in the funding mechanism provided additional incentives for managers.

Changes in the reimbursement method for U.K. Hospital reimbursements moved from block funding to payment by results (PBR). Under PBR funding, providers received a fixed level of revenue for each procedure (Cooper et al., 2011). PBR funding is similar to the diagnostic related group method developed in the United States (Cooper et al., 2011). A set reimbursement rate per procedure allowed managers to increase profit margins by performing procedures that aligned with the strategic strengths of their hospital (Wæraas & Sataøen, 2014). Transparency within the reforms led to public disclosure of metrics regarding the NHS.

Increased transparency and the NHS Staff Survey. As noted by Roland and Rosen (2011), the NHS reforms included increased transparency to promote patient choice and encourage competition. Lagu, Goff, Hannon, Shatz, and Lindenauer (2013) suggested that the data transparency within the NHS is a model for the U.S. health care system. The transparency initiatives also provided researchers with secondary data regarding staff surveys and quality indicators.

Developed in 2002, the NHS Staff Survey included instruments from prior research regarding work conditions of health care workers (Forsman, Rudman, Gustavsson, Ehrenberg, & Wallin, 2012). Researchers attributed the development of the

NHS Staff Survey to Michie and West (Boström, Rudman, Ehrenberg, Gustavsson, & Wallin, 2013; Forsman et al., 2012). The development of a framework that integrated managerial and psychological methods might provide pathways for increased organizational effectiveness (Michie & West, 2004). NHS Staff Surveys questions regarding employees' attitude toward recommending their employer to family/friends provided an insider's assessment of quality (Dixon-Woods et al., 2014).

In addition to the family and friends test of quality (Dixon-Woods et al., 2014), NHS patients had access to quality metrics. Researchers studied patients who perished following NHS inpatient care (n = 1,000) in the context of the Donabedian Triad (Hogan et al., 2014). Developed in 1996, the Donabedian Triad provided the framework for evaluating patient outcomes that resulted from the interaction of the proper structure aligned with an appropriate process (Banerjee, Stanton, Lemer, & Marshall, 2012).). Data from the NHS Staff Survey regarding safety culture served as an indicator of structure (Hogan et al., 2014). Hogan et al. (2014) relied upon safety incidents as reported in the National Reporting and Learning System and information regarding hand washing from the NHS Inpatient Survey to determine process. The Health Protection Agency provided Methicillin-resistant Staphylococcus aureus diagnosis reports and the Hospital Episodes Statistics contained 28-day readmission data that Hogan et al. used as outcome indicators. My focus moved toward the literature regarding the theoretical framework and conceptual models.

Reasoned Action Theory and Conceptual Models of Nurse's Intention to Leave

This subsection begins with the literature that grounded reasoned action theory as the theoretical framework. Next is a discussion of Herzberg's two-faction theory that researchers have used regarding turnover that did not align with the authority of managers within the NHS. The final subsection contains my discussion of four models developed for nurses regarding turnover, ITL, and intention to stay. There were differences within the four models concerning the inclusion of job satisfaction in models of nurse turnover.

Reasoned action theory. Theorized in 1975 by Fishbein and Ajzen with an expansion in 1980, the reasoned action theory is a theory of explanations for human behavior (Ajzen & Fishbein, 1980). According to the reasoned action theory, intentions are indicators of motivational levels (Ajzen, 2012). Intentions arise when the attitudes held by a person align with that person's perceptions of the attitudes of influential others (Ajzen & Fishbein, 1980). Researchers' support for the reasoned action theory integrated (a) the conceptual breadth of the theory (Liou, 2009), (b) acceptance as a frequently cited theory of intentions (Allen et al., 2014), and (c) that reasoned action theory is applicable for evaluating complex decisions (Prestholdt et al., 1987).

While intentions are powerful predictors of behavior, there are two intervening conditions. The intentions must persist and the behavior must be within the control of the person (Ajzen & Fishbein, 1980). These conditions are similar to issues raised in two articles summarized in the review of the literature.

Persistence of the intentions aligns with the dynamic component of ITL advocated by Chen, Ployhart, Thomas, and Bliese (2011). Chen et al. (2011) proposed that both the ITL level and an analysis of the level of ITL over time provided necessary information. Some conditions regarding employment might be beyond the employee's control. Hom et al. (2012) described employment arrangements such as employment contracts, which prohibit employees from acting on their turnover intentions. In the framework of the proximal withdrawal states, constrained employees who wish to leave represented trapped stayers (Hom et al., 2012). The development of the reasoned action theory set the framework for examining withdrawal states as a formative stage of ITL (Bergman et al., 2012).

Managers might benefit from responding to emergent ITL as opposed to reacting to turnover. Reasoned action theory formed the foundation for using ITL as a precursor for turnover (Bergman et al., 2012). From a practitioner's vantage, managers might have an opportunity to address problems during the formative stages of ITL and prevent turnover (Bergman et al., 2012). Prestholdt et al. (1987) drew a similar conclusion that reasoned action theory might provide hospital managers with an efficient method to manage nursing turnover. Prestholdt et al. found statistically significant evidence ($p <$ .001) that supported reasoned action theory using an instrument that measured hospital nurse's ($n = 942$) ITL compared to subsequent behaviors. Building on the theoretical foundation of reasoned action theory, researchers found statistically significant relationships between job satisfaction ($p < .03$) and intention to stay among Canadian nurses ($n = 155$) working in long-term care (McGilton et al., 2013). Application of

reasoned action theory applied across service sector occupations to employees' ITL. Based on the reasoned action theory, academics found that service employees (n = 1,250) reported a significant statistical relationship, which was -.302, $p < .01$ between abusive supervisors and ITL (Tzafrir, Gur, & Blumen, 2014). There were competing conceptual models as options for the theoretical framework contained in the extant literature. In the 21st century, the models of nursing turnover proposed by Hom et al. (2012) and Tourangeau et al. (2010) included theoretical support from reasoned action theory. In my review of the literature, I also considered a motivational theory that included factors that were outside of a NHS manager's scope of authority.

Herzberg's two-factor theory. Turnover researchers used Herzberg's two-factor theory as the theoretical underpinning for studies. Developed in 1966 the two-factor theory is a motivational theory (Hunt et al., 2012). According to Hunt et al. (2012), the two-factor theory came about based on data from college-trained professionals. Satisfaction levels lead to motivation levels with extrinsic factors linked to dissatisfaction and satisfaction associated with intrinsic factors (Hunt et. al, 2012; Tourangeau, Wong, Saari, & Patterson, 2014). Examples provided for extrinsic factors were employee compensation (Hunt et al., 2012) and workload (Tourangeau et al., 2014). Intrinsic factors incorporated work content, particularly work that was engaging and that aligned with the employees need achievement (Hunt et al., 2012). Additional intrinsic factors were work relationships and mentorship programs (Tourangeau et al., 2014). Conducting searches of the two-factor theory within ITL research, the following applications increased my understanding of the two-factor theory.

The National NH Survey was a countrywide survey of nursing home employees in the U.S. (Hunt et al., 2012). Applying secondary data from the National NH Survey researchers used the two-factor theory and found support for programs designed to increase retention rates of nursing home nurses in the United States (Hunt et al., 2012). Extrinsic factors measured in the National NH Survey included paid time off, retirement benefits, and medical insurance benefits (Hunt et al., 2012). Examples of intrinsic factors examined by Hunt et al. were employee recognition incentives, career ladders, tuition reimbursement, and attendance awards. Nursing homes with higher levels of employee retention included more tuition reimbursement and career promotions in their total compensation programs compared to low retention nursing homes (Hunt et al., 2012). Nursing homes with low retention rates addressed fewer extrinsic factors such as providing paid time off and funding retirement plans (Hunt et al., 2012).

In South Ethiopia, Asegid et al. (2014) tested the two-factor theory in a mixed methods study. Based on the responses to a 32-item overall satisfaction instrument nurses were deemed as satisfied or dissatisfied when their score was above or below the question mean (Asegid et al., 2014). According to Asegid et al., nurses indicated that sources of dissatisfaction included promotion (41.3%), professional training (43.8%), and total compensation (34.3%). Nurses expressed that the sources of satisfaction included relationships with leaders (57.0%), recognition in the workplace (50.4%), and 54.5% for work environment/group cohesion (Asegid et al., 2014).

Conducting a two-phase study of nursing faculty (n = 650) in Ontario Canada, Tourangeau et al. (2014) tested intrinsic and extrinsic factors. Examples of statistically

significant findings were overall workload ($p = .031$), manageable class size ($p = .024$), benefits supporting education/conference ($p < .001$), and advancement opportunities ($p < .001$; Tourangeau et al., 2014). Among the disincentives found by Tourangeau et al. were inadequate leadership ($p = .025$), inadequate salary ($p < .001$) and mandatory retirement ($p < .001$).

There are two reasons why I omitted the two-factor theory as my conceptual framework. First, application of the two-factor theory included a focus on job satisfaction (Hunt et. al, 2012; Tourangeau et al., 2014), while reasoned action is an inclusive theory (Liou, 2009). There is disagreement among developers of employment intention models regarding job satisfaction. Within the four models included in the literature, there was theorized support of job satisfaction (Brown et al., 2014, Hom et al., 2012; Price & Mueller, 1981). However, Tourangeau et al. (2010) put forward that nurses developed ITL in direct response to workplace conditions without recognizing intervening changes in job satisfaction. The study included the examination of components of the determinants of hospital nurses intention to remain employed as theorized by Tourangeau et al. (2010). As there is disagreement regarding the relationship between job satisfaction and ITL, I viewed my research through the more inclusive reasoned action theory. Furthermore, the 400,000 NHS employees are subject to labor agreements (Keogh & Kleebauer, 2014). Therefore, extrinsic factors such as paid time off and retirement plans are subject to union agreements and are outside of the control of hospital level managers. In a comprehensive review of the literature, Cowden et al. (2011) concluded that theoretical frameworks for nurse's employment intentions research included conceptual

turnover models. Within the existing research, I considered conceptual models of nursing turnover, intention to leave employment, and intention to stay employed.

Four models of nurse turnover. Multiple models of nursing turnover spanned time and crossed nursing disciplines. My review of the literature included four models of employment intentions (a) causal model of nursing turnover, (b) proximal withdrawal model (c) determinants of hospital nurses intention to remain employed, (d) factors influencing nurse managers' intention to stay. I grouped the first two models as foundation and successor while I reviewed the final two models in chronological order.

Causal model of nursing turnover. In developing the causal model of nursing turnover in 1981, Price and Mueller (1981) combined the theoretical and empirical traditions from economics, psychology, and sociology. As of December 2015, Google Scholar records point to 1,085 works that included a citation of the causal model of nursing turnover. I considered using the NHS Staff Survey data to test the causal model of nursing turnover. However, a search of the citing articles did not produce researchers who examined the constructs in this study. For example, searching within the research that included a citation of the causal model of nursing turnover for the keyword harassment resulted in articles concerning sexual harassment but no study contained harassment similar to workplace bullying. While testing the causal model of nursing turnover was not a good fit for the data there are commonalities between the causal model of nursing turnover and my research. Price and Mueller indicated that employees form expectations regarding employee preferences regarding how organizations treat their employees. If the organization failed to meet the employees' expectations, Price and

Mueller predicted the employee would develop an increased intention to leave. The prediction that employees are more likely to leave organizations that fail to meet the workers' expectations is consistent with social exchange components of leader-member exchange and perceived organizational support noted by Colquitt et al. (2013). The rewards and punishments in the workplace formed a nexus of the economic and psychological tradition (Price & Mueller, 1981). In a zero tolerance for bullying workplace, an employee might expect a reward for reporting bullying behavior. However, if the manager practiced hostile avoidant leadership, the manager may respond to the report of harassment by retaliating against the informant (Jackson, Hutchinson, Peters, Luck, & Saltman, 2013). The dependent variable in the causal model of nursing turnover is turnover. I used measurements of turnover intentions therefore other models provided a closer alignment with my research question. In addition to citing the causal model of nursing turnover, authors have expanded on the model.

Researchers adopted theoretical models to provide new options for measuring constructs. While Price and Mueller (1981) measured turnover over a one-year period, Hom et al. (2012) adopted intention to leave as a proxy for turnover in their 2012 model of proximal withdrawal states. Hom et al. also introduced proximal withdrawal states, which are conditions where employees have various levels of organizational commitment after the employee developed their ITL.

The proximal withdrawal model. The proximal withdrawal model developed by Hom et al. (2012) included three categories of employees who developed an ITL that aligned with my study. Enthusiastic leavers have options available and the desire to leave

(Hom et al., 2012). When an enthusiastic leaver resigns, the organization is subject to the implications of turnover. Managers who mitigate the formation of ITL and reduce the number of enthusiastic leavers should have better control over labor costs. Conversely, reluctant stayers and trapped stayers hold an intention to leave but either have obligations that prohibit leaving or have no employment alternatives (Hom et al., 2012). Reluctant stayers and trapped stayers might exhibit greater levels of counterproductive workplace behaviors (CWB) as well as higher levels of work avoidance behaviors (WAB; Hom et al., 2012). Among the enthusiastic leavers category, employees who experienced workplace shocks such as bullying, or interactions with toxic supervisors also participated in CWB and demonstrated WAB (Brewer & Kovner, 2014). Indicators of CWB included withholding information from co-workers and committing acts of sabotage (Hom et al., 2012). WAB behaviors included increased absenteeism and employee who arrived late for work (Hom et al., 2012). The extant literature regarding proximal withdrawal states is emergent. WAB and CWB informed the business implications and opportunities for positive social change. I monitored the emerging literature for research that tests the proximal withdrawal states model regarding nurses. However, the use of the proximal withdrawal states model to as a predictive model of ITL is nascent (Maertz, 2012). The third model of nursing employment intentions omitted job satisfaction as a predictor variable.

Determinants of hospital nurses intention to remain employed. Tourangeau et al. (2010) obtained information from Canadian nurses (n = 78) in focus groups to develop their model, determinants of hospital nurses intention to remain employed. Contrary to

the forced choices of the Price and Mueller (1981) surveys, the participants in the Tourangeau et al. study provided open-ended feedback to inquiries regarding the desire to remain with or to leave their current employer. This open-ended feedback provided a contrarian view of the ITL model.

A notable challenge to previous research is that none of the nurses in the Tourangeau et al. (2010) focus groups used job satisfaction as a factor that influenced intention to leave. Nurses reported eight thematic categories that changed their intention to leave. In the context of my predictor variables, nurses valued their interpersonal relationships with supervisors (Tourangeau et al., 2010). Employees also preferred working for supportive managers who exhibited fairness toward their employees (Tourangeau et al., 2010). The desire for nurses to remain employed due to supportive practices extended beyond the supervisor to the organizational level (Tourangeau et al., 2010). Tourangeau et al determined that nurses also valued their interpersonal relationships with co-workers. Nurses viewed bullying as an adverse aspect of interpersonal relationships and bullying decreased a nurse's intention to remain employed (Tourangeau et al., 2010). My review of the literature included a study by Carter and Tourangeau (2012) that confirmed the determinants of hospital nurse intention to remain employed model. Carter and Tourangeau used data from the 2009 NHS Staff Survey but did not include managerial response to errors/near misses. This study aligned with testing some of the determinants of hospital nurse intention to remain employed model. Researchers used varied combinations of survey questions to measure intention to leave or measured turnover.

Factors influencing nurse managers' intention to stay. The previous models addressed intentions of all nurses. In response to a gap in the literature regarding nurse managers, Brown et al., (2013) developed a conceptual model of factors influencing nurse managers' intention to stay. Noting the international concern regarding turnover among nursing managers, the foundation for the model arose from studies conducted in six OECD countries (Brown et al., 2013).

The model of factors influencing nurse manager's intention to stay aligned with the questions from the NHS Staff Survey examined in this study. A complete list of the questions used in this study is in Appendix B. Brown et al. 2013 also aggregated constructs supported by earlier researchers. Within the model, there are three categories of constructs: organizational factors, role factors, and personal factors (Brown et al., 2013). Brown et al. presented the three organizational factors as a Venn diagram. Culture is an organizational factor while leadership, support, communication, and violence occupy the intersection of organizational factors and role factors (Brown et al., 2013). Job satisfaction was the sole construct common to the three factors (Brown et al., 2013). Based on their review of the foundational studies, Brown et al. ranked the organizational factors.

Organizational culture and values were the leading organizational factors and key cultural components included treating employees with respect and an emphasis on excellence (Brown et al., 2013). Brown et al. (2013) confirmed the importance of leadership behavior that included feedback, support, and communication across organizational layers. Leadership behavior as a role factor influenced personal factors,

particularly when inadequate support led to a diminished sense of value or trust (Brown et al., 2013). Brown et al. noted the importance of leadership actions that are consistent with policies and procedures. Leaders who failed to act on reported violations of policies and procedures demonstrated a form of equivocal avoidant leadership (Jackson et al., 2013). Avoidant leaders undermine employee trust (Jackson et al., 2013).

In summary, the reasoned action theory proposed by Fishbein and Ajzen as updated in 1980 in conjunction with the conceptual models of the employment intentions of nurses provides the theoretical lens for examining the overarching research question. The next subsection contains the literature regarding the first predictor variable.

Job Satisfaction

Job satisfaction is the first predictor variable in this study. Job satisfaction is an integral component of three of the four models of nurse turnover/ ITL included in this review of the literature. There is an abundance of literature concerning nurses in the various stages of leaving employment. To narrow the search I refined the search terms to the three Boolean phrases “job satisfaction” “intention to leave” “intention to stay” and two filter terms, turnover and nurse. The primary search excluded articles published prior to 2011. The snowball approach of examining articles cited in the primary search results and referrals from journal websites revealed additional articles for consideration. I organized this subsection in the following subcategories. The first subcategory is definitions of job satisfaction as found in ITL research. The next subsection includes literature concerning geographic regions and instruments for measuring job satisfaction.

In the final literature subgrouping, I combine the construct, job satisfaction as used in the ITL models and methods for measuring job satisfaction.

Definitions of job satisfaction. I selected "job satisfaction is the extent to which employees like their work" (Price, 1981, p. 608) to form the operational definition of job satisfaction. This definition is consistent the definition of individual's overall sentiment regarding their employment used in a study of German health care professionals (Goetz et al., 2013). The Price (1981) definition of job satisfaction grounded a meta-analysis of 100 papers regarding job satisfaction levels of hospital nurses (Lu et al., 2012). Locating a working definition of job satisfaction required a secondary search within the extant literature regarding job satisfaction and ITL.

Researchers tended to agree that job satisfaction is an emotional response by employees regarding their jobs, yet researchers studied this complex phenomenon based on loose definitions (Ravari, Bazargan, Vanaki, & Mirzaei, 2012). Job satisfaction contained a national culture component as confirmed in an empirical study of nurse's ITL across four African nations (Blaauw et al., 2013). There is growing agreement to expand the concept of job satisfaction.

The Price 1981 definition was a static measure of job satisfaction. Using a static measure, we expect two employees with the same response regarding imminent ITL held a similar motivation to leave employment (Chen et al., 2011). Chen et al. (2011) argued that a dynamic measure of ITL was stronger than the static measure. In the context of the NHS Staff Survey data, the following is an example of the active component of ITL levels. Employee A and employee B indicated agreement with the question regarding

intention to leave as soon as they find another position to the 2011 NHS Staff Survey. Chen et al. suggested this response has additional value if we know how employee A and employee B responded to the 2010 NHS Staff Survey. ITL measures in the NHS Staff Survey measured the agreement with intentions to leave. Therefore, managers who were interested in reducing turnover would prefer disagreement to the ITL questions. If employee A reported a strongly agree in 2010 and checked agree for 2011, expecting better days to come, this employee might remain employed (Chen et al., 2011). In contrast, if employee B selected the neutral option during the 2010 NHS Staff Survey and agreed in the 2011 administration, employee B developed an increased ITL and might have a greater likelihood of leaving (Chen et al., 2011). The NHS Staff Survey is a static survey, which prohibits testing a dynamic relationship. There is a nascent alternative for the job satisfaction construct.

The etymological root of satisfaction was the Latin word for enough; for this reason, satisfaction reflects a sense of acceptability as opposed to a notion of wonder or excitement (Warr & Inceoglu, 2012). Warr and Inceoglu (2012) advocated a shift from job satisfaction to job engagement to recognize increased levels of energy and activation. While satisfied employees have a comfort level with their position, engaged employee are enthusiastic about their work (Warr & Inceoglu, 2012). Warr and Inceoglu promoted additional research regarding job satisfaction and job engagement. The questions in NHS Staff Surveys that included ITL did not align with measuring job engagement. The next section is a summary of the job satisfaction and ITL research.

Job satisfaction and intention to leave employment. There is an established history of scholarly work regarding job satisfaction and ITL as documented in the following summary. The majority view of ITL researchers was that attitudinal precursors such as job satisfaction were central to the process of determining to remain employed or to leave employment (Hom et al., 2012). In the 21st century, contributions to the body of literature arose from multiple countries and across nursing specialties.

In a correlational study of Belgian acute care nurses (n = 287), there was a statistically significant ($F(2,284) = 112.4$; $p < .001$) relationship between job satisfaction and ITL (De Gieter, Hofmans, & Pepermans, 2011). Two groups emerged in the Belgian study; in one group job satisfaction was the sole predictor of ITL (De Gieter et al., 2011). In the second group, there was an association between both job satisfaction and organizational commitment and ITL (De Gieter et al., 2011). Nurses (n = 935) employed at four hospitals in Italy responded to surveys regarding ITL (Portoghese, Galletta, Battistelli, & Leiter, 2014). The data provided empirical support that job satisfaction mediated the relationship between leader-member exchange (LMX) and ITL at the individual level (Portoghese et al., 2014). Extending the analysis to the workgroup level the nurses indicated that increased job satisfaction related to high levels of satisfaction when nurses worked in a high LMX setting (Portoghese et al., 2014). Nurses across Europe participated in a large-scale study of dissatisfaction and ITL.

To determine the factors that contribute to ITL, hospital nurses (n = 23,159) from 10 European responded to questions regarding dissatisfaction and ITL (Heinen et al., 2013). The measure for ITL consisted of a question if the nurse intended to leave within

the next year in dyad format, an affirmative response prompted a follow-up question (Heinen et al., 2013). Nurses who planned to leave within 12 months clarified their intention to leave their position or if they intended to leave the nursing profession (Heinen et al., 2013). Nurses employed in the U.K. (n = 2,918) revealed that 44% planned to leave their employer while 10% expected to leave nursing (Heinen et al., 2013). As measured by the Practice Environment Scale Nursing Work Index Revised the factors that U.K. nurses deemed as statistically significant ($p < .05$) in conjunction with ITL included: (a) leadership, (b) participation in hospital affairs, (c) full-time employment, and (d) burnout (Heinen et al., 2013). Researchers also conducted studies with African nurses.

In a study to determine the association between workplace politics, job satisfaction, and ultimately ITL, hospital nurses (n = 610) in Ghana participated in a correlational study (Atinga et al., 2013). In a nine-item Likert-type scale, nurses indicated their perceptions regarding treatment in the workplace in terms of favoritism and fairness (Atinga et al., 2013). Atinga et al. (2013) reported a statistically significant negative association between workplace politics and job satisfaction ($p < .000$), and a positive association between workplace politics and ITL ($p < .005$).

Noting that historically job satisfaction research among health care workers consisted of small-scale surveys Blaauw et al. (2013) conducted a multi-dimensional study using a stratified sample (n = 2,220). The participants included registered nurses, allied health workers, and enrolled nurses (Blaauw et al. 2013). Health care workers surveyed worked in the lower income countries of Tanzania and Malawi, as well as the

middle-income country of South Africa (Blaauw et al., 2013). Among health care workers in the three countries, South African health care workers reported the highest level of dissatisfaction (47.9%) resulting in 41.4% who expressed their ITL (Blaauw et al., 2013). The percentage of health care workers in South Africa who indicated their ITL (Blaauw et al., 2013) was similar to the rate expressed by U.K. nurses (Heinen et al., 2013), at 41.4% and 44% respectively. Having presented a summary of job satisfaction and ITL, my emphasis for the next section is organizational culture.

Organizational Culture

Organizational culture is the second predictor variable for my research. The constructs of organizational culture (culture) and organizational climate (climate) had distinct roots and researchers gravitated to different research methods for each of these constructs. Culture came up from an anthropological foundation, culture reflected the social relationships developed in the workplace, (Asif, 2011) and researchers expressed a preference for qualitative methods (Asif, 2011; Schneider, Ehrhart, & Macey, 2013). The origins of climate came from psychology, climate referred to effect of organizational systems on employees (Asif, 2011), and the research was dominated by quantitative methods (Asif, 2011; Schneider et al., 2013). The terms began to meld; culture was a reflection of how employees complete their work, while climate became a means for employees to define culture (Karassavidou et al., 2011; Poghosyan, Nannini, Finkelstein, Mason, & Shaffer, 2013). Another description of climate was the employee's perception of culture (Karassavidou et al., 2011). Over time, the delineations between the constructs of culture and climate blurred.

Researchers used the different constructs of climate and culture interchangeably (Poghosyan et al., 2013). Michie and West (2003) referred to organizational climate, organizational culture, and organizational culture/climate in their governmental report regarding the development of the NHS Staff Survey. Schneider et al. (2013) noted that practitioners preferred to describe survey findings as evidence of culture irrespective of the survey instrument. Brownson et al. (2014) addressed the fading delineation by combining the constructs into organizational climate/culture. After considering, the origins and melding of the constructs I decided on how employees accomplish their work as the operational definition of organizational culture (Karassavidou et al., 2011). The following subsections included my synthesis of the existing literature concerning organizational culture within three categories of organizational culture: (a) leadership, (b) harassment, and (c) managers response to errors/near misses. There is a plethora of information regarding leadership, harassment, and ITL. Research regarding error/near misses and ITL is evolving within the organizational subculture known as safety culture.

Leadership. Regarding leadership, the NHS Staff Survey supported an examination of leadership in the context of interactions with immediate supervisors and leadership at the organizational level. Leader-member exchange theory (LMX) developed by Graen and Uhl-bien in 1995 in conjunction with perceived organizational support (POS) as developed by Eisenberger, Huntington, Hutchinson, and Sowa in 1986 are leadership theories at the supervisory level and organizational level respectively. There are attributes shared by the positive leadership styles POS and LMX. The review of the literature also includes avoidant leadership.

LMX, POS, and avoidant leadership. Following 25 years of research to develop an alternative leadership style, LMX arose as a new theory that contained features of both transactional leadership and transformational leadership (Graen & Uhl-bien, 1995). The social exchange between leaders and followers is transactional that develops into a transformational social exchange (Graen & Uhl-bien, 1995). While earlier theorists focused on the roles of the leader and roles of the followers, Graen and Uhl-bien (1995) noted the central point of leadership is the relationship between leaders and followers. Therefore, LMX researchers considered the intersection of the three domains of leader, follower, and relationship.

Graen and Uhl-bien (1995) proposed that leadership included trust, respect, as well as a shared obligation within the leader follower dyad. Managers attempt to build one to one relationships with employees (Graen & Uhl-bien, 1995). According to Graen and Uhl-bien, employees who place trust in their supervisor defined a high LMX relationship. Leadership behaviors included mutual learning and accommodation; accommodating the unique needs of the follower should produce better outputs (Graen & Uhl-bien, 1995). The dyadic nature of LMX support extended the theory from individuals to groups based on a series of interdependent dyads or a network of associations (Graen & Uhl-bien, 1995). Graen and Uhl-bien also proposed alignment between LMX and workplace conditions. In general, LMX aligned with the area between the two ends of the spectrum defined at one end by structured tasks, strong leader power, and members who accept leaders and at the other end by unstructured tasks, weak leader power, and members who do not accept the leader (Graen & Uhl-bien, 1995). Specifically, Graen and

Uhl-bien theorized that LMX is a good fit for continuous improvement projects. Researchers continued to use LMX singularly or in combination with related theories in managerial research concerning nurses. However, turnover researchers should look beyond the employee-supervisor leadership relationships and examine leadership at the higher organizational levels (Waldman, Carter, & Hom, 2012). POS theory moves beyond dyadic leadership relations found in LMX.

Consistent with the motivational effort from expectancy theory, employees who developed a higher level of perceived organizational support (POS) also developed an increased effort-outcome expectancy (Eisenberger, Huntington, Hutchison, & Sowa, 1986). Operationally, these employees viewed increased efforts as a pathway to more rewards. Employees formed their POS based on the anticipated organizational response to selected events such as employee illness, high levels of performance, fair compensation programs, and employee errors (Eisenberger et al., 1986). In both LMX and POS, the employee developed a perception of relationships at work.

A commonality with POS and LMX is that each theory involved the employees who rewarded supportive relationships with increased performance (Casimir, Ng, Wang, & Ooi, 2014). Under LMX, employees evaluated their relationship with a supervisor while viewed through the POS lens employees considered the relationship with the organization as a whole (Casimir et al., 2014). Likewise, Eisenberger et al. (1986) indicated that employees personified the organization based on the responses from managers. Colquitt et al. (2013) completed a meta-analysis, concluding that POS and LMX are indicators of social exchange quality. Furthermore, Mayer and Sparrowe (2013)

indicated the integration of LMX and POS is an accepted practice as both theories contained the employee's perception of one or more superiors as an explanatory variable. Employees do not view all responses from managers as positive outcomes.

While employees favored LMX and POS, working for an avoidant leader might present a challenging work environment for employees. Avoidant leadership is a counterproductive leadership style characterized by responses from leaders (Jackson et al., 2013). Jackson et al. (2013) described three forms of avoidant leadership: placating avoidance, equivocal avoidance, and hostile avoidance. When leaders adopted a placating avoidance the leader acknowledged the concern but did not act on the concern (Jackson et al., 2013) The employees reacted positively to the acknowledgement however, the good feelings faded quickly (Jackson et al., 2013). Leaders who adopted a wait and see attitude toward problems practiced equivocal avoidance (Jackson et al., 2013). Employees who work for equivocal leaders did not know what to expect when the employee reported a problem. In the hostile avoidant leadership style, the leader viewed the informant as the problem and overlooked the underlying condition (Jackson et al., 2013). According to Jackson et al. the literature regarding avoidant leadership is emergent.

Research of the variables grounded in LMX, POS, and avoidant leadership. There is abundant research in the area of LMX and nurses employment turnover. Han and Jekel (2011) described LMX in terms of the quality of the relationship between the individual and the manager. Managers who constructed strong LMX relationships had employees that indicated statistically significant lower intentions to leave (Han & Jekel, 2011). Kang, Stewart, and Kim (2011) surveyed Korean nurses to find empirical

evidence supporting a relationship between LMX and organizational commitment. Similarly, Biron and Boon (2013) determined Dutch nurses who provided care to the elderly valued high LMX that produced a lower level of ITL. At a deeper level, empirical evidence supported that LMX is more important to high performers compared to low performers (Biron & Boon, 2013). Therefore, managers who attempt to fine-tune persistency rates from reducing turnover to reducing turnover among high performers, these managers should invest in developing good leadership relationships to increase LMX (Biron & Boon, 2013). Robson and Robson (2015) found statistically significant support that high LMX reduced the intention to leave. LMX was the second most important consideration for nurse's intention to leave behind the attachment to the work (Robson & Robson, 2015). In the United Emirates, Abu Elanain (2014) confirmed a statistical relationship between higher LMX and lower intention to leave. Abu Elanain continued the research tradition of characterizing high LMX, as relationships based on trust, respect, and loyalty. The relationship between employee and manager developed from a series of interactions (Abu Elanain, 2014). As suggested by Graen and Uhl-bien (1995) LMX applied beyond the individual including work units, groups, and organizations.

Collective turnover is the measure of turnover at the unit or organizational level (Heavey, Holwerda, & Hausknecht, 2013). Heavey et al. found support for LMX in that positive perceptions of relationships with supervisors had a significant negative association with the nurse's intention to leave. Researchers also noted the attributes of LMX in relation to employee's intention to stay without directly attributing LMX.

Italian nurses provided statistical evidence to Galletta et al. (2011) that indicated when supervisors built supportive relationships, the nurses to preferred working for that supervisor. Galletta et al. (2011) attributed the supervisor nurse relationship to social exchange processes instead of LMX. Conversely, El Akremi, Colaianni, Portoghese, Galletta, and Battistelli (2014) referred to the social exchange theory as proposed by Blau (1964) as a theoretical framework for building interpersonal relationships. Eberly, Holley, Johnson, and Mitchell (2011) proposed that both parties in a relationship have a duty to work toward repairing or advancing the relationship. Similarly, reciprocity would lead employees to assist employers when the employer provided aide to the employee (Eisenberger et al., 1986). The NHS Staff Survey included questions regarding the managerial response to reported harassment and managerial response to errors/near misses. The LMX research for managers' feedback regarding errors/near misses is developing.

Reporting errors is a requisite tool for improving safety performance, yet employees might adopt a position of *defensive silence* to resist reporting errors (Kim et al., 2014). Defensive silence occurred when individuals protected themselves from negative consequences by withholding information (Kim et al., 2014). Kim et al. (2014) found the loyalty component of LMX counteracted defensive silence. Korean nurses with high LMX relationships expressed a statistically significantly greater willingness to report errors in comparison to colleagues who reported low LMX (Kim et al., 2014). Conversely, avoidant leadership suppressed the reporting of errors (Jackson et al., 2013).In a multi-national study of European nurses, the researchers determined that

English nurses were more likely to report lapses in care in comparison to their Norwegian counterparts (Aiken, Rafferty, & Sermeus, 2014).

Researchers have also examined harassment in the context of LMX. Nelson et al. (2014) empirically confirmed that LMX moderated the perceptions of bullying among Brazilian nurses. Samnani, Singh, and Ezzedeen (2013) proposed that targeted employees considered LMX when attempting to determine the bully's intent. While employees valued LMX and POS behaviors, employees tend to reject supervisors who do not accept supervisory responsibility.

To deliver quality care nurses must work together across care units and work shifts. Nurses valued leaders who fostered teamwork, communication, and leaders who mentored staff (Anonson et al., 2014). At the other end of the leadership spectrum are the leaders who avoided making decisions and leaders who relied on rewards and punishment (Anonson et al., 2014). Anonson et al. (2014) described leaders who avoided decisions to correct workplace behaviors as passive-avoidant leaders. Surveys completed by acute care nurses (n = 117) at a hospital in the southern US provided empirical evidence that nurses who perceived managers as passive-avoidant leaders expressed lower satisfaction scores (Bormann & Abrahamson, 2014). When nurses responded to questions regarding their lived experiences with bullying and avoidant leadership, the nurses lamented that the leaders took no action to address reports of bullying (Anonson et al., 2014). The next subsection is a review of literature regarding harassment as of nurses in the workplace.

Harassment. Every nurse working for the NHS expected protection from a zero tolerance policy regarding staff harassment in the workplace (Woodrow & Guest, 2012).

Ingrained attitudes toward harassment within the NHS led to the conclusion that harassment was a contributor to the continued organizational dysfunctional within the NHS (Pope & Burnes, 2013). Nurses continued to self-report harassment and their perceptions of how managers responded to the self-reported incidents. As indicated in Appendix B, the secondary data contained nurse's perceptions of their employers' response to harassment, bullying, or abuse (HBA). There is existing literature for both predictor variables and harassment, bullying, or abuse. Therefore, the search of the literature included the components of HBA. Additionally, based on the key terms within the literature I extended the search strings to include incivility, horizontal violence, and lateral violence. As the literature regarding supervisory responses to HBA is emergent, I reviewed additional literature to ground broader issues as regards HBA. The supplemental literature included the individuals impacted by HBA and the international prevalence of HBA.

Managerial response to HBA. Nurses commented on their reasons for entering the nursing field and described their decisions based on virtuous reasons including providing care for others, to make a difference, and altruism (Price, McGillis Hall, Angus, & Peter, 2013). However, the workplace conditions for nurses lead nurses to question their capacity to remain in the field. When nurses encountered toxic behaviors, they attempted to correct the circumstances for their benefit, to improve the working conditions for colleagues, and provide better patient care (Gaffney, DeMarco, Hofmeyer, Vessey, & Budin, 2012). The nurses who attempted to address HBA might report the incident to a supervisor.

Supervisors have three options for addressing a problem. A supervisor can attempt to solve the problem, ignore the problem, or retaliate against the person who reported the problem (Jha & Epstein, 2013). When supervisors provided a positive response by attempting to solve the problem nurses were less likely to develop an intention to leave (Gaffney et al., 2012). When employees perceived that perpetrators faced consequences, the employees who stepped forward to report the incident were empowered (Deery, Walsh, & Guest, 2011). Nurses empowered by supportive managers might have superior approaches for responding to urgent issues regarding patient care (Laschinger, Nosko, Wilk, & Finnegan, 2014). Unfortunately, nurses also experienced supervisors who ignored the problem or punished the employee who brought the HBA to light (Gaffney et al., 2012). Retribution for reporting HBA included increased assignments and scheduling on undesirable shifts (Gaffney et al., 2012). Nurses interacted with a range of individuals during their training and professional careers thereby creating an exposure to HBA for groups of individuals and HBA from multiple parties.

Individuals impacted by HBA. There are multiple parties affected by HBA behaviors. The individuals directly impacted in HBA included targets and witnesses (Egues & Leinung, 2013). Additional health care stakeholders that might suffer the effects of HBA included the target's family and friends, the employer, and society (Barber, 2012). Participants in HBA were members of a variety of stakeholder groups (Vogelpohl, Rice, Edwards, & Bork, 2013). Bullies included fellow nurses, nursing supervisors, and individuals in the nurse's care (Vogelpohl et al., 2013). Researchers who

focused on a subset of HBA behaviors defined the relationship between the perpetrator and target. For example, nurse to nurse bullying represented horizontal violence (Egues & Leinung, 2013). Researchers who focused on a macro-analysis also developed a set of operational definitions. The broader term workplace incivility referred to workplace behaviors that did not follow the expectations of mutual respect (Taylor, Bedeian, Cole, & Zhang, 2014). Hom et al. (2012) advanced the notion of negative principal forces when they combined bullying between colleagues with abusive leadership practices.

Nurses developed the skills to perform their duties within established hierarchies. The existing research confirmed multiple steps in which nurses faced exposure to HBA. Nurses started their pedagogical journey in classrooms with faculty members and continued to learn from preceptors in clinical settings (Foley, Myrick, & Yonge, 2012). Faculty members subjected students to HBA behaviors (Berry, Gillespie, Gates, & Schafer, 2012). Student nurses might encounter their first exposure to HBA during clinical training (Clarke, Kane, Rajacich, & Lafreniere, 2012). During field assignments, nursing students looked to preceptors for support and guidance while the student adjusted to clinical rotation demands (Walker, Earl, Costa, & Cuddihy, 2013). Preceptors should support their nursing students and shield them from HBA (Walker et al., 2013). The successful nursing student relationships with their preceptor arose from interactions that did not include bullying (Foley et al., 2012). However, students continued as both targets and witnesses of HBA when preceptors continued to practice HBA (Berry et al., 2012). As new nurses transition, they move from junior ranks to senior ranks at which time the junior members became the HBA targets of the senior members (Phillips, Kenny,

Esterman, & Smith, 2014). HBA is a recognized reality of work for newly licensed nurses (Berry et al., 2012; Read & Laschinger, 2013).

Exposure to HBA continued across a nurse's career. Nurses between the age of 40 and retirement were more likely to encounter HBA in both the witness and target roles (Longo, 2013). In terms of impact, nurses who reported bullying from supervisors and physicians expressed the greatest impact on the nurse's ability to maintain peak performance (Berry et al., 2012; Etienne, 2014). Nurses regularly performed their duties in areas with other individuals; exposure to HBA influenced both the targets and the witnesses. Witnesses comprised the largest group directly impacted by HBA (Egues & Leinung, 2013). In addition to involving multiple parties, HBA is an international concern.

Prevalence and rationale for perpetrating HBA. In 2009, 25% of British nurses reported bullying from patients/families and 17% indicated bullying behaviors by colleagues/supervisors (Deery et al., 2011). However, researchers found opposing issues regarding nurse's reports of HBA. In particular, evaluating HBA at the granular level of harassment, bullying, and abuse present a number of challenges for researchers. First, the definitions of bullying were not consistent across the literature (Foley, Myrick, & Yonge, 2013; Purpora, Blegen, & Stotts, 2012). Furthermore, individual nurses might have different thresholds for acceptable behaviors.

Samnani et al. (2013) postulated that power distance mediates the line between acceptable and unacceptable behavior, employees with a high power distance might accept a power imbalance. Additionally, female nurses viewed bullying behaviors

differently than male nurses (Foley et al., 2013). Australian regulators have initiated operational definitions for harassment and bullying (Meloni & Austin, 2011). Repeated behaviors are necessary to constitute bullying (Meloni & Austin, 2011). With different concepts of the behavior that constitutes HBA, there are concerns regarding the accuracy of the number of incidents reported by nurses. Researchers suggested that violence against nurses was underreported (Magnavita & Heponiemi, 2011; Meloni & Austin, 2011). At the same time, Meloni and Austin (2011) found that some reports of HBA were false or erroneous. There are multiple motivational rationales for perpetrating HBA.

There is a tradition of linking HBA to a sense of powerlessness as predicted by the oppressed group theory postulated by Freire in 1970 (Purpora et al., 2012). According to the oppressed group theory, nurses viewed themselves as powerless; therefore, they struck out against each other (Purpora et al., 2012; Rodwell & Demir, 2013; Szutenbach, 2013). Perpetrators might commit HBA as a form of hazing (Vogelpohl et al., 2013). Additionally HBA might reflect a power struggle (Longo, 2013). A bully might emerge as an informal leader particularly if management refused to respond to reports of bullying (Hutchinson, 2013). A common theme for these notions of HBA is that HBA was a negative behavior. In contrast, Turkish nurses perpetrated HBA as a rational behavior to improve their standing within the organization (Katrinli, Atabay, Gunay, & Cangarli, 2010). Bullying another nurse might suppress the performance of the bullied nurse that positioned the perpetrator for better work assignments and improved performance appraisals (Katrinli et al., 2010). Barber (2012) implied that bullying was so engrained that bullying might be a management technique. What managers intended as a strict

management style others might interpret as bullying (Barber, 2012). Middle managers encountered faced accusations of bullying when they attempted to enact the priorities of senior managers (Hewison, Gale, Yeats, & Shapiro, 2013). Health care managers are moving from placing blame for mistakes as reflected in the following review of the safety culture literature.

Managerial response to errors/near misses. Under the reformed funding system, NHS hospitals competed to provide care to U.K. residents and international patients (Lunt et al., 2013). The increased transparency within the NHS reforms included public access to quality indicators (Lagu et al., 2013). Patient safety is a fundamental indicator of quality care (Kohlbrenner et al., 2011). Researchers stated that improvements in patient care required learning from errors and preventing errors (Naveh & Katz-Navon, 2014; Stavrianopoulos, 2012). Medical errors included both adverse events and near misses that put patient safety at risk (Hwang & Park, 2014). Health care providers must identify the sources of error/near misses to develop corrective actions (Naveh & Katz-Navon, 2014). When nurses failed to report errors/near misses or when there was no remedy for the reported unsafe practices, the problems continued (Chassin, 2013). The business consequences of failed attempts to implement corrective actions regarding errors/near misses might include, decreased staff morale, diminished patient safety, and loss of reputation (Rosenstein, 2011). In addition to promoting, the practice of reporting errors managers should avoid blaming the employees.

The health care industry embraced the safety culture developed for the nuclear processing industry (Stavrianopoulos, 2012). Moving toward a safety culture required

open lines of communication, a shared concept regarding the value of safety, and non-punitive response to errors (Stavrianopoulos, 2012). Stavrianopoulos (2012) stressed the importance of nurses providing information to leaders regarding the safety incidents/near misses. Supporting nurses who reported errors/near misses is the foundation for the identification and correction of unsafe work practices (Chassin, 2013). Halbesleben et al. (2013) confirmed that maintaining a safety climate in health care required congruency between managers' actions and organizational policies. To encourage reporting managers might view near misses as a communication issue as opposed to the near miss arising from the fault of an individual (Kim et al., 2014).

Kim et al. (2014) confirmed the importance of reporting errors/nears misses and further noted psychological barriers might hinder reporting. When a nurse contributed to an error, the nurse might experience humiliation that in turn could lead to changes in the nurse's attitude toward submitting reports (Kim et al., 2014). Nurses might remain silent beyond avoiding humiliation.

Another communication barrier is defensive silence; defensive silence is a mechanism in which individual purposefully remained silent to protect themselves from consequences (Kim et al., 2014). Defensive silence is cumulative as each deception increased the fear of detection (Kim et al., 2014). Kim et al. noted that defensive silence might spread between co-workers. Pope and Burnes (2013) described the prevalence of silence within the NHS as a response to indifference and retaliation for reporting problems as organizational silence. Leaders of a multi-cultural workforce ought to consider the interpersonal implications arising from cultural conditions. In an empirical

study Taiwanese employees in high risk employment (n = 535) demonstrated an inclination to withhold information regarding errors/near misses ($p < .01$) to maintain a harmonious workplace (Hsu & Lee, 2012). Organizational silence within the NHS contributed to the abject failure to provide quality care associated with the Bristol Infirmary deaths (Pope & Burnes, 2013). The process of deciding to report an error/near miss is complex with employees considering if reporting is mandatory/optional, and the employee's perceptions of the reactions to previous reports (Naveh & Katz-Navon, 2014).

Managers have four options for addressing a near miss/injury report. One is consistent with a safety culture while three of the responses are examples of avoidant leadership. A manager who supported a safety culture might accept the error/near miss report as the foundation for finding a way of preventing future occurrences (Stavrianopoulos, 2012). Supporting employees who reported errors/near misses might improve the safety culture resulting in improved patient safety and higher levels of job satisfaction (Goh, Chan, & Kuziemsky, 2013). While support for the employee who reported the error/near might result in positive outcomes, the avoidant leadership responses might lead to negative results.

Hostile avoidance is a subset of avoidant leadership in which the manager viewed the person who submitted the near/miss error report as the problem (Jackson et al., 2013). Jackson et al. noted that trusting an avoidant leader resulted in the reporters putting themselves in a dangerous position. Therefore, managers have a need to create a work environment that encourages reporting of errors/near misses (Kim et al., 2014). Using the

event as the foundation for improvement and using the retaliation are the ends of the continuum of responses to errors/near misses. Intermediate responses included placating avoidance and equivocal avoidance. Leaders demonstrated placating avoidance when they accepted the report but took no action (Jackson et al., 2013). Nurses described leaders in the equivocal avoidance mode as ambivalent (Jackson et al., 2013). The next section represented my review of the literature regarding the dependent variable intention to leave employment.

Nurse Intention to Leave Employment, Business Implications, and Positive Social Change

The dependent variable in this study was nurse's intention to leave employment (ITL). I have organized the literature regarding ITL into two subsections. The first subsection included summaries of the challenges regarding the definition of ITL and instruments to operationalize ITL. In the second subsection, I reviewed the business implications from failing to manage ITL and opportunities for positive social change available from managing ITL.

ITL definitions and instruments. In their exhaustive review of the literature Chan et al. (2013) concluded that a there is no commonly accepted definition of ITL for nurses. Operational definitions of ITL ranged from descriptions of a tendency to leave employment to definitions within which the nurses left the nursing field (Chan et al., 2013). Different definitions of intention to leave might explain some of the variance in the percentages of nurses who reported ITL (Heinen et al., 2013). Hayes et al. (2012) noted a similar lack of consistency in the defining turnover as applied to nursing research.

Without a consistent definition, it is difficult to compare turnover across organizations and in different periods. The operational definition of ITL for this study was the preference held by an employee to resign from their current position (Asegid et al., 2014) is in alignment with ITL as measured by the 2011 NHS Staff Survey. In contrast to the varied definitions, ITL and turnover scholars supported instruments that frame ITL questions in terms of urgency.

The secondary data from the NHS Staff Survey conducted in 2011 included questions that measured ITL at three urgency levels. The wording of the ITL questions is in Appendix B. In the first level of urgency, the question measured the employee's thought of leaving. The second urgency level was a measure of exploring job opportunities in the next 12 months. The most urgent level was an indication of employees who intended to leave as soon as they located another job. Researchers used the three-tiered NHS Staff Survey ITL measures (Buttigieg & West, 2013; Carter & Tourangeau, 2012; Woodrow & Guest, 2012). In contrast, the Anticipated Turnover Scale used to measured turnover intentions of Saudi Arabian nurses contained 12 items (Almalki, Fitzgerald, & Clark, 2012). Heinen et al. (2013) asked nurses from 10 European countries a dichotomous question if they intended to leave their employer within the next year. In a study of nurses providing long-term care, the measures of intention to leave included the concept of time for intention to leave, with leaving tied to determining if nurses would leave today if possible or if they were actively exploring options (Tummers, Groeneveld, & Lankhaar, 2013). The intention to leave question advanced by Han and Jekel (2011) measured an employees' consideration of leaving the

organization. Laschinger and Fida (2014) also used intention to leave as a proxy for turnover in their empirical time-lagged study of Canadian nurses preferences concerning authentic leadership. Employees moving amid the stages of intention to leave engaged in behaviors that had financial consequences and actions that presented opportunities for positive social change

Business implications and opportunities for positive social change. This subsection of the literature review included the literature on the topic of implications regarding nurses forming an intention to leave and nursing turnover. Employees develop an intention to leave employment (ITL) that might culminate in employee turnover (Hom et al., 2012). ITL is a leading precursor to turnover (Price & Mueller, 1981). A preponderance of nursing turnover researcher viewed turnover with an emphasis on ITL (Hayes et al., 2012).). I prepared a thematic design for the organization of this subsection. Hospitals have multiple stakeholders (Cardinaels & Soderstrom, 2013) which could come upon business implications or could make available opportunities for positive social change. The opening subsection contained the business implications for the organization. The subsection closes with the opportunities for positive social change for patient stakeholders and opportunities for positive social change for nurse stakeholders.

Business implications of ITL. As noted by Hausknecht and Trevor (2011) the importance of turnover research stems from the consequences of behavior regarding ITL. In their exhaustive review of the literature, Hayes et al. (2012) summarized the business implications of ITL in terms of reduced productivity, organizational inefficiency, and turnover costs. Researchers have modeled turnover costs in Australia, Canada, the United

States, and New Zealand (Li & Jones, 2013). Applying the Nursing Turnover Costs Calculation Methodology (NTCCM) the turnover of one nurse increased Australian hospital expenses by an average of $49,255 (Roche et al., 2014). The range of additional expenses attributed to turnover was $17,728 to $104,686 per nurse (Roche et al., 2014). Calculations within the NTCCM included direct costs for lost productivity of the remaining staff and the productivity lost during the work-in-phase of the replacement nurse (Roche et al., 2014). Roche et al. (2014) modeled the lost productivity as a new nurse enters the workplace at 15% of the total turnover cost. Nurses who have developed a level of ITL but have not acted on their intentions also increased the expenses of the health care provider.

Hom et al. (2012) proposed that delays between forming an ITL and turnover might lead to work avoidance behaviors (WAB). Absenteeism is an example of WAB (Hom et al., 2012). Absenteeism occurred when employees did not have the desire to work their scheduled assignments (Atinga et al., 2013). Atinga et al. (2013) found empirical evidence that supported the relationship between workplace politics and increased absenteeism as a WAB during formation of ITL. If NHS managers reduced absenteeism by one percent, £34.2 million might be available each year for other expenses (Walker & Bamford, 2011). Employees also missed work due to sickness. Exposure to bullying in the workplace increased the risk of an employee having a long-term absence due to illness by 92% (Ortega et al., 2011). Nurses with an ITL who remained employed may similarly participate in behaviors that reduced organizational effectiveness.

Employees with a diminished commitment to the organizational might consider actions that interfered with the fulfillment of the organizational mission. Detrimental actions by employees with a level of ITL resulted in lost performance and productivity (Chu, 2014). Atinga et al. (2013) described withholding effort due to employment disaffection as job neglect. Hom et al. (2012) provided a broader spectrum of behaviors within the realm of counterproductive work behaviors (CWB). Examples of CWB included avoiding work responsibilities, making disparaging remarks about their employer, and harassing fellow employees (Chu, 2014: Hom et al. 2012). Zhao, Peng & Sheard (2013) indicated that CWB by service workers affected fellow employees and customers. Specifically, service workers with increased ITL withheld effort that contributed to customer dissatisfaction (Kumar et al., 2014). The next subsection contained the opportunities for positive social change for patients and nurses.

Opportunities for positive social change for patients and for nurses. Mintzberg (2012) observed that patients sought out physicians to find a cure and patients looked to nurses to provide care. Hospital managers relied on nurses to provide safe and effective care (Wright & Khatri, 2014). Behaviors exhibited by nurses who have formed an ITL might diminish the quality of care provided by these nurses. CWB included employees withholding individual effort, withholding effort as a team member, and conducting personal tasks while at work (Klotz & Buckley, 2013). Providing quality care required teamwork particularly during the transfer of responsibility for care between shifts or across specialties (Effken et al., 2011; Estryn-Behar et al., 2014). Children were particularly sensitive to complete communication during care. Pediatric intensive care

patients had diverse body weights, which placed a special emphasis on complete exchanges of information regarding medication dosage (Blake, Leach, Robbins, Pike, & Needleman, 2013). When nurses withheld effort and failed to complete their assignments due to staff shortages, patients experienced increased rates of decubiti, falls, and infections (Kalisch & Xie, 2014). Increased workloads from absenteeism and others withholding effort might also influence the quality of care.

New nurses reported not having enough time to communicate with patients/families (Vogelpohl et al., 2013). Not devoting enough time to patient education is an example of missed care (Kalisch & Xie, 2014). Patients might respond to incomplete information with hostility (Vogelpohl et al., 2013) which may lead to diminished quality of life for nurses. When patients initiated bullying, this took a heavier toll on nurses compared to staff-to-staff harassment (Etienne, 2014). Employees considered the positive and negative features of their jobs. There are alternative theories and models regarding how employees process these evaluations. Having summarized the literature regarding the theoretical framework, the predictor variables, and the dependent variable the next section is my synopsis of the literature concerning methodology and design.

Methodologies and Design

The history of research regarding job satisfaction, organizational culture, and intention to leave included representative studies with qualitative and quantitative methods. The qualitative methods literature included the first phase of a mixed methods study regarding the factors that influenced Canadian home care nurses intent to remain

employed (Tourangeau et al., 2014). Qualitative methods research methods applied in the development of the proximal withdrawal model by Hom, Mitchel, Lee, and Griffith in 2012. Tourangeau et al. (2010) also used the qualitative method to build their model of hospital nurses intention to remain employed based on the lived experiences of hospital nurses. However, Allen et al., (2014) indicated that the majority of researchers concerned with continued employment used quantitative methods.

Quantitative methods may produce results with greater reliability, validity, and generalizability (Tillman et al., 2011). Within the quantitative method, ITL researchers maintained an overriding reliance on correlational designs (Allen et al., 2014). While Allen et al. attempted to detect a dominance of methods and for prevailing designs, other researchers completed systematic literature reviews. The comprehensive literature studies confirmed the prevailing use of the quantitative method and correlational design. Chan et al. (2013) considered 8,499 articles for their review of the literature regarding nurse's intention to leave. Within the 31 articles selected for comprehensive review, 29 authors used quantitative methods. Article titles in the reference list provided by Chan et al. (2013) reflected the interconnectedness terms regarding continued employment that included turnover, intention to leave, retention, and intention to stay. Conversely, Hayes et al. (2012) stated their goal for conducting a summary review was to provide a comprehensive collection of research regarding nursing turnover. Of the 51 articles studied by Hayes et al. (2012) regarding determinants of nursing turnover, 50 articles contained terminology that indicated quantitative methods. The publication dates for consideration for these literature reviews were January 2001 to January 2010 (Chan et al.,

2013) while Hayes et al. searched for the period 2006 to 2011. The following is a summary of the quantitative methods and correlational designs implemented by researchers in peer-reviewed articles I reviewed with publication dates from 2011 to 2015 inclusive.

Using secondary data precluded experimental design and quasi-experimental design. Using an experimental design regarding managers' response to HBA might also raise ethical concerns. Some nurses who experienced HBA encountered psychological harm (Laschinger & Nosko, 2013). Therefore establishing control groups in which the research withheld corrective actions could breach ethical responsibility. Researchers applied a range of correlational techniques regarding ITL. The secondary data provided by the NHS Staff Survey that measured the variables in this study were Likert-type questions. Therefore, I limited the review of the literature for this section to research that used Likert-type surveys

The 2011 NHS Staff survey consisted of a series of five-item Likert-type questions. Scholars disagreed regarding the statistical analysis of Likert-type questions. Boone and Boone (2012) stated there is no meaningful distance between Likert-type responses that resulted in ordinal scale data. A combination of four or more Likert-type questions transformed the information into a Likert scale, which resulted in interval scale data (Boone & Boone 2012; Norman, 2010). Ordinal scale data aligned with nonparametric analysis while interval scale data supported parametric analysis (Boone & Boone, 2012). In defense of parametric analysis of Likert-type data, Norman (2010) noted the prevalence of parametric examination of Likert-type data in the social sciences.

Analysis of 10-point Likert-type scale demonstrated no meaningful difference in the statistical evidence resulting from the conducting a Spearman correlation and performing a Pearson correlation (Norman, 2010). The following are exemplars of nonparametric research and parametric studies.

The nonparametric studies included correlational research and descriptive statistics. In an examination of the 2009 Staff Survey data, researchers found empirical evidence using a nonparametric pairwise test that supported the association between incivility and ITL (Pinder, Greaves, Aylin, Jarman, & Bottle, 2013). South African acute care nurses (n =935) indicated a statistically significant association ($p < .01$) among job satisfaction, adverse events, and ITL based on responses to the Likert-type questions from the RN4CAST instrument (Klopper, Coetzee, Pretorius, & Bester, 2012). In the United States responses from employees in neonatal intensive care units (n = 547) sustained an association between safety climate and working conditions $r_s(547) = .92$, $p < .0001$ (Profit et al., 2012). West and Dawson (2012) used histograms based on the 2009 NHS Staff Survey data to provide the descriptive statistics regarding recommended elements of organizational culture that aligned with health care quality goals. As noted by Norman (2010) social scientists have applied parametric analysis to data obtained with Likert-type instruments.

Using the data from the 2006 and 2009 surveys Woodrow and Guest (2012) discovered significant relationships using multiple linear regression between the variables staff aggression, supervisory support, and ITL. Woodrow and Guest used a subset of the NHS Staff Survey limiting the responses to nurses with n = 48,365 for 2006 and n =

55,381 for the 2009 survey. Woodrow and Guest (2012) found that a significant relationship between harassment and ITL for both years 2006 ($p < .001$) and 2009 ($p < .001$).

Buttigieg and West (2013) tested for moderation in the relationships between overload, hostility, and intention to leave while controlling for demographic variables. Delimiting the NHS Staff Survey data to employees of all acute care and specialist providers ($n = 65,142$), Buttigieg and West performed structural equation modeling followed by regression analysis to examine moderation. A significant positive correlation ($r = .22$) at $p < .01$ existed for turnover intentions and hostility, whereas a significant negative correlation existed for job satisfaction and hostility ($r = -.25$) at $p < .01$ (Buttigieg & West, 2013). Researchers who administered Likert-type instruments other than the NHS Staff Survey also used regressions.

In a cross-sectional study of hospital nurses working in Hong Kong ($n = 1,271$), a dichotomous instrument for measuring ITL resulted in the use of logistical regression (Choi, Cheung, & Pang, 2013). The data resulted in a significant ($p < .001$) between nurse's impressions of management and intention to leave (Choi et al., 2013). A mandated survey administered in 2003 to employees of NHS hospitals ($n = 2,221$) in London/ South East of England contained dichotomous questions regarding ITL (Deery et al., 2011). Accordingly, Deery et al. (2011) analyzed the Likert-type instrument for job burnout with ordinary least squares and logistical regression for ITL. As noted in this discussion researchers relied on secondary data from the NHS Staff Survey (Buttigieg &

West 2013; Woodrow & Guest, 2012). The subsequent subsection is a review of the literature regarding secondary data.

Secondary Data

In addition to selecting the research method and research design, researchers must also determine the sources of their data. In this section of the review of the literature, I summarized the literature that supported completing a study based on secondary data. The order of presentation of the literature is a macro level review of secondary data in research followed by the use of the NHS Staff Survey in studies with research questions similar to the research question in my research.

Macro level consideration of secondary data in research. Prior to the analysis of data, the researcher must gather data. Barriers faced by hospital employee researchers may occur at the institutional and again at the individual level. Hospital managers maintained institutional review boards that might delay or prevent researchers from conducting surveys (Secanell et al., 2014). Health care employees reported that they received an overabundance of requests to complete surveys from students and others, which resulted in study fatigue (Alvarez et al., 2012). A fundamental advantage to researchers using secondary data is that data already exists (Greenhoot & Dowsett, 2012).

Using existing data might reduce the time and expense associated with obtaining primary data (Dunn, Arslanian-Engoren, DeKoekkoek, Jadack, & Scott, 2015). Charlwood et al. (2014) indicated that in the 21st century, researchers have access to high-quality secondary research for conducting quantitative studies. The breadth of a governmental survey is beyond those typically available for independent investigators

(Boo & Froelicher, 2013). The large samples provided by national surveys might also make many constructs available for the researcher (Greenhoot & Dowsett, 2012). An advantage of large national samples over convenience samples is the large national samples have a lower exposure to threats to external validity (Boo & Froelicher, 2013).There are multiple challenges of using secondary data that offset the advantages of breadth and time.

With secondary data, the researcher selects the data; the researcher does not choose the questions used to gather the data (Boo & Froelicher, 2013). Therefore, the instrument used to generate the secondary data might not be the preferred instrument and researchers must be mindful of the measures reliability and validity (Greenhoot & Dowsett, 2012). The time to become familiar with the dataset might offset the time saved by not collecting data (Greenhoot & Dowsett, 2012). Ethically, secondary data purged of identifying information might provide information with low risk of breaching confidentiality (Dunn et al., 2015). Nevertheless, researchers must confirm that their use of the archival information is consistent with the disclosure notices given to the participants (Brakewood & Poldrack, 2013). Researchers have embraced the NHS Staff Survey as a credible data source.

NHS Staff Survey data. Researchers attributed the development of the NHS Staff Survey to Michie and West in 2002 (Boström et al., 2013; Forsman et al., 2012). Michie and West (2004) described developing a framework to integrate managerial and psychological methodologies that might contribute to organizational effectiveness. Pinder

et al., 2013 confirmed that the data from the NHS Staff Survey is a reflection of the organizational culture and health care quality indicators for NHS Trusts.

NHS Staff Survey data overview. The NHS databases provided access to the largest data source regarding U.K. health care professionals (Alvarez et al., 2012). NHS Staff Survey responses demonstrated the value of the data as a detailed source of demographic information (King, Dawson, Kravitz, & Gulick, 2012). Woodrow and Guest (2014) described the NHS Staff Survey as a source of validated measures of employee attitudes. The NHS Staff Survey data provided a validated source of employee attitudes regarding morale and organizational culture in a mixed methods study of the roll out of a patient safety initiative (Benning et al., 2011).

The national scope of the NHS Staff Survey was a major advantage for researchers (Pinder et al., 2013; Woodrow & Guest, 2014). Trust administrators used a random assignment to identify the potential participants for the NHS Staff Survey (Pinder et al., 2013; Woodrow & Guest, 2014). There are multiple examples in the extant literature based on NHS Staff Survey in which the researchers examined some of the variables that I examined. NHS staff demonstrated consistent response rates and the response rates for the NHS Staff Survey provided a benchmark for a study of turnover intentions held by oncological staff (Jones, Wells, Gao, Cassidy, & Davie, 2013).

Examinations of the study variables based on NHS Staff Survey data. Researchers have combined different predictor variables with the three levels of intention to leave as the dependent variable using NHS Staff Survey data. A statistically significant relationship existed between workplace aggression and a higher intention to leave

(Woodrow & Guest, 2012). Based on data from both the 2006 and the 2009 surveys the employees' perception of their managers' response moderated the relationship between harassment and intention to leave (Woodrow & Guest, 2012).

Using 2009 NHS Staff Survey Data, researchers tested the determinants of hospital nurses intention to remain employed proposed by Tourangeau et al. (2010), regarding the relationship between experiencing violence and intention to leave (Carter & Tourangeau, 2012). Carter and Tourangeau (2012) did not find statistical evidence regarding the support of managers as a moderating factor between harassment and intention to leave. In contrast, Woodrow and Guest (2012) found a weak moderation between supervisors' support and intention to leave. The weak moderation of support from senior managers in the relationship between work stressors and intention to leave is consistent with the empirical evidence from the 2010 NHS Staff Survey (Buttigieg & West, 2013). A comparison of the data from 2011 NHS Staff Survey with the 2010 NHS Staff Survey results indicated a deterioration in the staff attitudes regarding supportive management (West & Dawson, 2012). To date, I have found no research that included managerial response to errors/near misses and nurse's intention leave using NHS Staff data.

Transition

Section 1 contained background information as regards job satisfaction, organizational culture, and nurse's intention to leave employment (ITL). The problem and purpose statements aligned with the examination of the relationship if any between job satisfaction, organizational culture, and ITL. The data to support this research were

the responses to the 2011 NHS Staff Survey. To confirm that NHS managers faced business problems as the result of nurse's ITL Section 1 included information regarding the structural and reimbursement reforms at the NHS. The NHS Staff Survey is secondary data gathered with a governmental instrument. Accordingly, Section 1 contained information to support the academic rigor of secondary research and the robust data provided by the NHS Staff Survey results. Researchers studied ITL in many countries and across national borders due to the business implications, along with the consequences to patients from decreased quality of care, and a diminished quality of life for nurses. Common themes for the ITL model builders and ITL scholars included the predictor variables job satisfaction and organizational culture in relation to the dependent variable ITL. Researchers considered the variables using qualitative and mixed methods. However, the dominant mindset was a quantitative method and correlational design.

In Section 1, I provided the underpinning for this research. In Section 2, I included the purpose statement and stated the role of the researcher. In the context of using the secondary data from the 2011 NHS Staff Survey, I presented a more focused discussion of (a) participants, (b) population and sampling, (c) ethical research, (d) instrumentation, and (e) data collection technique. Other topics contained within in Section 2 are the arguments supporting data analysis and study validity. Section 3 encompasses the presentation of the findings, the application for professional practice, and implications for positive social change. Section 3 also contains the recommendations for stakeholders, recommendations for scholars, personal reflections, and the study conclusion.

Section 2: The Project

In Section 1, I provided an overview of the components of the completed study. Section 1 also included a review of the professional and academic literature to position this research in the existing literature. In Section 2, I merge the overview with the extant literature to provide additional detail and further justifications for the decisions outlined in Section 1.

Section 2 opens with the purpose statement as stated in Section 1. The purpose statement provided the foundation for contextualizing each of the following subsections. I examined secondary data. Using secondary data is beneficial because the data already exists (Greenhoot & Dowsett, 2012), and secondary data might expand the breadth of information available for researchers (Boo & Froelicher, 2013). My decision to examine secondary data altered some of the characteristics of the research. I addressed the changes that arose from using secondary data within the headings (a) role of the researcher, (b) participants, (c) population and sampling, (d) ethical research, (e) instrumentation, and (f) data collection technique. Further decisions reviewed in Section 2 include research method, research design, data analysis, and study validity. A transition and summary close the study.

Purpose Statement

The purpose of this quantitative, correlational study is to examine the relationship among nurse's job satisfaction, organizational culture, and nurse's ITL. The predictor variables are nurse's job satisfaction and organizational culture. The dependent variable

is nurse's ITL. I examined secondary data from the population of 163 acute care NHS England (NHS) Trusts as measured by the 2011 NHS Staff Survey. The 2011 NHS Staff Survey is the most recent survey that included ITL questions. The results of a better understanding of the correlates from this study may provide opportunities for positive social change for patients and nurses.

Reduced ITL might lessen medical errors and quality of life for nurses. As nurses develop ITL, they might deliberately avoid communications (Hom et al., 2012). Communication is critical for preventing health care errors (Brunetto et al., 2013). Likewise, nurses with higher levels of ITL could have higher absenteeism rates (Hom et al., 2012). Increased absenteeism resulted in nurses working longer shifts. Nurses who worked additional hours reported a decreased quality of life (Lu et al., 2012).

Role of the Researcher

As the sole researcher for this study, I accepted three roles. First, as a researcher pursuing a Doctor of Business Administration degree, I accepted the role of developing research that might promote business success (Banerjee & Morley, 2013). As a Doctor of Business Administration student at Walden University, I also acknowledged the role to promote research that might lead to positive social change (Salter, 2013). Lastly, I was responsible for adhering to the standards of academic rigor while examining questions that mattered to managers (Markides, 2011).

My experience as a practitioner included consulting with managers of U.S. health care organizations and human services providers. I supported manager's efforts to control labor costs, to implement safe work environments, and to give quality care. I had no

relationship with the respondents to the 2011 NHS Staff Survey. The data supporting this research is the result of human responses to a survey. The Belmont report protocol governed research with human subjects based the three principles of respect for the participant, beneficence, and justice (U.S. Department of Health & Human Services, 1979). Operationally, these doctrines required informed consent, comparing risks to benefits, and selecting study participants (Brakewood & Poldrack, 2013).

The issue of confirming informed consent might be problematic with secondary data (Brakewood & Poldrack, 2013). Survey documents established respect for the participants in terms of optional participation and protecting respondent anonymity. The survey packet included a frequently asked questions (FAQ) document. The FAQ included a statement that confirmed the option to avoid completing the survey (Picker Institute Europe, 2013). The NHS Staff Survey questionnaire included wording that confirmed the processing contractor only released response information after the removing all identifiers from the data (National Health Service, NHS Staff Survey Co-ordination Centre, 2011).

The determining factor for one view of beneficence was access to treatment (Davison et al., 2013). A potential conflict from withholding treatment from corrective procedures regarding bullying was a justification for avoiding an experimental design. Participants might also benefit from changes implemented as the result of study findings (Matlakala, Bezuidenhout, & Botha, 2014). As noted in the implications for positive social change, the study results might inform changes that might improve the working conditions for nurses as well as the potential improvements in patient care.

Regarding the selection of participants, McDonald and Patka (2012) stated that the justice dimension is a function of the inclusion of members in contrast to excluding individuals. Trust administrators selected the potential participants for the NHS Staff Surveys by a random sampling technique (Pinder et al., 2013; Woodrow & Guest, 2014). Alignment with the research question led to a post hoc exclusion of respondents outside of nursing in acute care hospitals. Limiting the data to nursing staff supports testing the models of nurses employment intentions noted in the theoretical framework. The following section is a discussion of participants within the milieu of secondary research.

Participants

I examined the secondary data from the public information collected from the 2011 NHS Staff Survey. An advantage using of secondary data is the data already exists (Greenhoot & Dowsett, 2012). Accordingly, the researcher bypasses the issues of gaining access to participants and does not need to establish a working relationship with participants. I studied secondary data to overcome two barriers encountered in gaining access to conduct research with hospital-based nurses. First, hospital managers might require approval by the hospital's institutional review board prior to undertaking research with hospital employees (Secanell et al., 2014). In addition, health care workers reported survey overload, which might suppress response rates (Alvarez et al., 2012). The breadth of information available from the archival data bolstered avoiding the constraints that limited access to data.

Working with secondary data might require repetitive analysis to determine the research questions that align with the existing data (Boo & Froelicher, 2013). Greenhoot

and Dowsett (2012) described the time required to understand the secondary data as the tradeoff for not consuming time to gather data. A review of the extant literature confirmed the alignment of between the NHS Staff Survey respondents and my research questions. Researchers also used NHS Staff Survey information in conjunction with other documents to study business implications and positive social change.

Analysis of data from 2006 and 2009 NHS Staff Surveys confirmed the moderation of managers' response to the relationship between harassment in the workplace and ITL (Woodrow & Guest, 2012). Carter and Tourangeau (2012) relied upon the responses to the 2009 NHS Staff Survey to test elements of the determinants of hospital nurses intention to remain employed developed by Tourangeau et al. (2010). In a government-sponsored research project, researchers documented associations between a culture of shared trust and improved patient outcomes (West & Dawson, 2012). With access to information across governmental agencies, West and Dawson (2012) compared the results of the 2009 NHS Staff Survey with patient evaluations, mortality reports, turnover, MRSA infection rates, and financial results. The summative statement from West and Dawson was that the overriding finding was that a positive workplace culture is the optimal setting for U.K. health care delivery system. While there is an agreement regarding using the data from respondents of NHS Staff Survey, there were differences in the selection of the research methods and designs.

Research Method and Design

The selection of the research method and research design required completing a multistep process. Zou, Sunindijo, and Dainty (2014) suggested a three-step process that

began with framing a research question. The nature of the research question informed the understanding of the research created and the methodology by which researchers produced knowledge (Zou et al., 2014). This section includes my discussion of the rationale for using a quantitative method and correlational design to examine the relationship among job satisfaction, organizational culture, and ITL.

Research Method

The three research methods are quantitative, qualitative, and mixed methods (Williams, 2007; Zou et al., 2014). Research based on quantitative methods relies on numerical data and researchers apply deductive reasoning to join research with underlying theories (Zou et al., 2014). Quantitative data obtained with an instrument is independent of the researcher (Williams, 2007). In contrast, Carr (1994) described qualitative methods research as an inductive process by which a researcher developed knowledge from the interacting with individuals. The mixed methods option is a combination of quantitative and qualitative methods, which blended the inductive and deductive processes (Williams, 2007).

The quantitative method was the prevailing format for research regarding ITL (Allen et al., 2014; Chan et al., 2013). Advantages of quantitative analysis regarding nursing research included increased validity, generalizability, and reliability (Tillman et al., 2011). The realization of an ITL by nurses led to research questions across the globe. Specific research based on quantitative methods regarding nurse's intentions regarding employment occurred in the (a) United Kingdom (Buttigieg & West, 2013; Deery et al.2011;Woodrow & Guest, 2012), (b) across Europe (Heinen et al., 2013), (c) United

States (Hunt et al.,2012), (d) Canada (Laschinger & Fida, 2014; Tourangeau et al., 2014), and (e) Australia (Duffield et al., 2014). In addition, the quantitative method supported research regarding nurses ITL across four African nations (Blaauw et al., 2013) and in Hong Kong (Choi et al., 2013). Equally as important to alignment with the research question, the quantitative method aligned with the secondary data.

The alignment of secondary data and the quantitative method occurred in two areas. First, the quantitative method is consistent with data obtained with surveys (Zhou et al., 2014). Next, Zhou et al. (2014) advocated for the quantitative method with large sample sizes. The secondary data from government-sponsored surveys provided researchers with responses from participants that exceeded the typical range available to independent researchers (Boo & Froelicher, 2013). The sample from the 2011 NHS Staff Survey after limiting respondents to nurses employed in acute care trusts and cleaning missing data (n = 21,257) was greater than the sample (n = 16,707) of the 2009 NHS Staff Survey reported by Carter and Tourangeau (2012). Similar to Carter and Tourangeau, I filtered the NHS Staff Survey data to exclude workers outside of acute care nursing. The hard numerical data available from a large organization such as the NHS required a quantitative method (Carr, 1994). I considered both the qualitative method and mixed methods options but eliminated these options for the following reasons.

Conclusions from a qualitative research contained depth along with increased detail but had limited generalizability (Zou et al., 2014). For that reason, the findings from qualitative research based on interviews with six intensive care nurses from six

hospitals located in Africa were limited to those particular units (Matlakala et al., 2014). Individual participants provided the data for qualitative research by interaction with the researcher or agreeing to direct observation of study participants (Williams, 2007; Zou et al., 2014). Alternatively, the researcher obtained access to qualitative archival data (Williams, 2007). In each instance, the researcher obtained consent from the participants. There are two barriers to gaining access to qualitative data from hospital nurses. At the institutional level, the researcher must obtain the approval from the organization's institutional review board (Secanell et al., 2014). At the individual level, nurses reported a saturation of requests to participate in research (Alvarez et al., 2012). The mixed methods approach might mitigate the limitations on generalizability (Zou et al., 2014). However, researchers must still overcome the access issues noted above. Mixed methods research results in expending additional time and resources (Tillman et al., 2011). In summation, I employed the quantitative method; the next subsection is a summary of my reasoning for carrying out a correlational design.

Research Design

I completed a correlational design. The correlational design was the prevailing research design used by employment intentions scholars (Allen et al., 2014). Williams (2007) summarized the correlational design in terms of testing the relationships between variables with statistics. The correlational design applied in the suggested applications by which Alvarez et al. (2012) demonstrated the efficacy of using secondary data. Correlational analysis of NHS Staff Survey data resulting in correlations ($p < .001$) for each of the 11 questions was used to confirm the determinants of nursing intention to

remain employed model (Carter & Tourangeau, 2012). The correlational design applied to NHS Staff Survey data confirmed the relationship between patient incivility and ITL (Pinder et al., 2013). Woodrow and Guest (2012) also implemented a correlational design with NHS Staff Survey data in their examination of multiple forms of aggression and ITL. Selecting a design for this study necessarily eliminated other designs.

To improve inferences regarding causation, Allen et al. (2014) promoted a move toward experimental designs. Based on my review of the literature, I did not accept this recommendation. Three reasons for my decision to reject an experimental design involved access to participants, the time commitment for participants, and ethical considerations.

The access and time issues are interrelated in that there is an opposition to participating in research and participants in experimental studies have multiple time commitments. Institutional workers reported burnout from unrelenting requests to complete surveys for research projects (Alvarez et al., 2012). The experimental designs required time to develop information pretreatment, treatment application, and posttreatment data gathering. Participants reported that their time commitment was a reason for dropping out of an experimental study of acceptance and commitment therapy (Dalrymple & Herbert, 2007). Experimental studies should include a random group that does not receive the experimental treatment (Gerardo, Lavonas, & McKinney, 2014). An acceptable ethical benchmark existed for withholding treatment in situations where the adverse consequences are temporary (Gerardo et al., 2014). However, the impact of bullying in health care included symptoms similar to post traumatic stress disorder such

as depression and suicidal ideation (Wilson et al., 2011). Therefore, withholding treatment for bullying behaviors might result in permanent harm and violate the ethical benchmark. Having supported the use of a quantitative method and a correlational design, my objective in the next subsection is to provide the justifications for my population and sample.

Population and Sampling

The population for this research was all U.K. nurses employed by acute care trusts. The potential participants in the 2011 NHS Staff Survey included all employees across all of the trusts within the NHS (Woodrow & Guest, 2012). The sampling protocol for the 2011 NHS Staff Survey included sending survey forms to a probabilistic simple random selection (random sample) of trust employees (Admasachew & Dawson, 2011; Woodrow & Guest, 2012). All employees of every trust were eligible for inclusion in the simple random sample (Woodrow & Guest, 2012). Data from a U.K. governmental agency indicated total employment within the NHS was 1,361,533 (Health and Social Care Information Centre, 2013). The NHS Staff Survey administrators followed a tiered sampling scheme.

For the 2011 NHS Staff Survey, a trust with up to 600 employees provided their employee census while a trust with more than 3,000 employees developed a simple random sample of 850 employees (NHS Staff Survey Co-ordination Centre, 2011). The census sampling for smaller trusts and random sampling at the larger trusts also applied to the 2009 NHS Staff Survey (Carter & Tourangeau, 2012). The sample size for acute care trusts nurses after cleaning for missing data from the 2011 NHS Staff Survey of

21,257 exceeded the sample size of 16,707 acute care nurses reported by Carter and Tourangeau (2012). In comparison, a comprehensive review of quantitative research in the nursing field indicated that 6% of the researchers examined datasets greater than 5,000 cases (Gaskin & Happell, 2014).Secondary data might provide researchers with a sufficient sample size to ensure statistical power without incurring unnecessary expenses (Gaskin & Happell, 2014).

Random sampling is a method of selecting a sample in which every potential participant had the same probability of receiving an invitation to participate in the study (Weinberg & Abramowitz, 2002). In addition, the selection of each potential participant is independent of the choice of any other participants (Weinberg & Abramowitz, 2002). Random samples provided researchers with information that is more generalizable and has better rigor (Forsyth, Agrawal, & Krizek, 2012). Another advantage of randomization is the eliminated self-selection bias (De Visschere, Schols, van der Putten, de Baat, & Vanobbergen, 2012). The NHS Staff Survey random sample is in contrast to the voluntary participation at the employer level. Voluntary participation introduced potential self-selection bias in a study of European nurses (Secanell et al., 2014). The random sampling method is also subject to weaknesses.

A potential weakness of a random sample is that the researcher might randomly oversample a subset of the population (Weinberg & Abramowitz, 2002). Weinberg and Abramowitz (2002) illustrated oversampling, with an example of political attitudes expressed by participants classified by gender identity within political affiliations. In the context of this study, male nurses reported greater levels of workplace harassment

compared to female nurse (Ariza-Montes, Muniz, Montero-Simo, & Araque-Padilla, 2013). To protect the anonymity of the respondent the Picker Institute Europe suppressed demographic information at the respondent level.

Secondary researchers must determine which questions aligned with the data (Greenhoot & Dowsett, 2012). In the context of U.K. acute care nurses, the overarching research is: What is the relationship among job satisfaction, organizational culture, and intention to leave employment? Alignment of the sample with the overarching research question required adjustments to the data. I used a subsample of the data to limit the respondents to U.K. nurses employed by acute-care trusts. This modification is consistent with the work of Carter and Tourangeau (2012) in their alignment with their research questions regarding workplace conditions and ITL among acute care U.K. nurses. According to Carter and Tourangeau (2012), the subsample also aligned with the testing the determinants of hospital nurses intention to remain employed model.

In addition, the overall NHS Staff Survey data included other respondents that might confound the results. The unaltered public data files included responses from nurses and other employees across the NHS. Nurses in other specialties encountered different work environments in comparison to acute care nurses, resulting in different factors regarding the formation of employment intentions (McGilton et al., 2013). I also filtered the subsample to remove other health care professional specialties that might have muddled the results. There is little research regarding pharmacist's formation of an intention to leave (Mak, March, Clark, & Gilbert, 2013); therefore, the responses from pharmacists might alter the results. Having identified the study population and sample,

my purpose for the following section is to review the ethical considerations regarding the study participants.

Ethical Research

The goal of the ethical researcher is to act responsively and to make moral choices across the research process (Wester, 2011). Examining secondary data removed me from direct interactions with research participants. My goal is this section is to document that the secondary data came about from ethical and responsible methods along with my intentions to continue to honor the participants.

In the fall of 2011, the NHS Staff Survey Co-ordination Centre administered the survey by mailing surveys and a frequently asked questions file to the homes of the potential participants (National Health Service, NHS Staff Survey Co-ordination Centre, 2011). Researchers must be responsible for three freedoms for their study participants (Vervliet, Rousseau, Broekaert, & Derluyn, 2015).These are the freedom to withhold participation, the freedom to withdraw at any time, and the freedom to omit responses (Vervliet et al., 2015). The frequently asked questions file included a statement confirming that participation was optional (National Health Service, NHS Staff Survey Co-ordination Centre, 2011). Missing data indicated that some participants elected to withhold their responses at the question level. Likewise, the response rate is a proxy for some potential participants choosing to withhold from participating. Secondary researchers encountered a second tier for consent in that the participants might not expect the data might support multiple studies (Yardley, Watts, Pearson, & Richardson, 2013). The cover note in the NHS Staff Survey contained a notice confirming that the data might

support additional studies (National Health Service, NHS Staff Survey Co-ordination Centre, 2011). Another concern in secondary research is protecting the participant's privacy (Kaye, Boddington, de Vries, Hawkins, & Melham, 2010).

The issue of informed consent and the ability to withdraw from participation in a study are techniques for managing potential physical harm and protecting privacy (Kaye et al., 2010). An independent contractor gathered and protected the NHS Staff Survey data. In 2011, the Picker Institute Europe provided the contract services that included (a) the initial mailing, (b) two follow-up requests, (c) removal of identifiers, (d) data analysis for governmental reports, and (e) archiving the data (National Health Service, n.d.). For the 2011 NHS Staff Survey, employees of the Picker Institute Europe removed all personal identifiers (National Health Service, n.d.).

In the 21st century, governments opened the access to data secured by public funds to increase transparency and support use of the data by outside parties (McDonald, & Léveillé, 2014). Appendix A contains a copy of the open government license to use public data granted by the Controller of Her Majesty's Stationary Office. Following the receipt of the Walden IRB approval number 09-04-15-0388923 I contacted the data specialists with the Picker Institute Europe requesting the 2011 NHS Staff Survey data. As noted in Appendix F at the direction of the Picker Institute Europe I retrieved the 2011 NHS Staff Survey data from the U.K. Archives. Appendix C contained my completion certificate for training regarding protecting human participants. Even with publically accessible data, researchers should set standards for retaining their work (McDonald, &

Léveillé, 2014). I transferred the data from the completed study to a jump drive for storage in my personal safe for 5-years.

Data Collection Instruments

Data obtained from a quality instrument is necessary to support quality findings (Zhou et al., 2014). I used secondary data acquired in the 2011 NHS Staff Survey without making any adjustments/revisions to the instrument. Researchers attributed the development of the NHS Staff Survey to Michie and West in 2002 (Boström et al., 2013; Forsman et al., 2012). Pinder et al., 2013 described the data from the NHS Staff Survey as an examination of organizational culture and health care quality indicators.

NHS Staff Survey Questions Formats, Sources, and Scoring

The NHS Staff Survey Co-ordination Centre, which located within the Picker Institute Europe, administered the 2011 NHS Staff Survey (National Health Service, NHS Staff Survey Co-ordination Centre, 2011). The secondary data is available to the public via the internet. As noted in the open license in Appendix A, the results are freely available to researchers. The NHS Staff Survey questions that aligned with the constructs examined in the study were in a five-point Likert-type format. The scale anchors were *strongly disagree* and *strongly agree*.

Likert-type questions measure data on the ordinal scale (Boone & Boone, 2012). Aggregating and summing four or more Likert-type questions produced Likert scale data on an interval data scale (Boone & Boone, 2012). The questions from the 2011 NHS Staff Survey that align with the hypothesis appear in Appendix B. I aggregated the six Likert-type organizational culture questions and the seven job satisfaction Likert-type

questions. However, the intention to leave responses remained as Likert-type questions resulting in ordinal scale data.

Scholars recognized Michie and West as the developers of the NHS Staff Survey to Michie and West in 2002 *(*Boström et al., 2013; Forsman et al., 2012*)*. Michie and West (2004) described developing a framework to integrate managerial and psychological methodologies that might contribute to organizational effectiveness. Extant literature from within health care management and other sectors informed the selection of the questions for the instrument (Michie & West, 2004). A standardized survey provided NHS Trusts with a tool with the psychometric properties of reliable and valid measures of staff attitudes (Michie & West, 2003).

Researchers have commented on the construct validity in general terms and with information regarding the specific underlying instruments. Michie and West (2003) aligned the constructs with academically recognized instruments and included psychometric properties on selected instruments. As examples, Michie and West provided evidence of internal consistency with reported levels of Cronbach's alpha along with documenting instrument names/developers.

The NHS Staff Survey contained a range of validated measures of attitudes regarding the workplace (Woodrow & Guest, 2012). In the context of my research, Michie and West (2004) addressed the constructs of organizational culture/climate, communication, leadership, and employee behaviours. Researchers have identified some of the underlying instruments adapted to develop the NHS Staff Survey.

Buttigieg & West 2013 indicated the NHS Staff Survey contained transformational leadership questions adapted from the Transformational Leadership Questionnaire developed in 2001 by Alimo-Metcalfe and Ablan-Metcalfe. The questions regarding job satisfaction mirrored the questions from 1979 Job Satisfaction Scale developed by Warr-Cook-Wall (Buttigieg & West, 2013; Michie & West 2003). The measures of job design also came from an established instrument. The source of the job design questions was the Job Diagnostic Survey developed by Hackman and Oldham (Buttigieg & West, 2013, Michie & West, 2003). The measures of the dependent variable intention to leave paralleled the Intention to Quit Scale developed by Mobley, Horner, and Hollingsworth in 1978 (Buttigieg & West, 2013, Michie & West, 2003). The Intention to Quit Scale is an instrument for the examination of withdrawal states (Mobley, Horner, & Hollingsworth, 1978). Mobley et al. (1978) combined validated instruments that measured overall satisfaction, facet satisfaction, and thinking of quitting from full-time hospital nurses (*n*= 203) employed in the Southeastern region of the United States. After 47 weeks, the researchers coded actual turnover for the participants (Mobley et al., 1978). The 2011 NHS Staff Survey contained 160 questions (NHS Staff Survey, 2012). Scoring the instrument was the responsibility of the NHS Staff Survey Co-ordination Centre (National Health Service, NHS Staff Survey Co-ordination Centre, 2011). In a study that included all of the 2007 NHS Staff Survey questions and patient outcomes, there were 12, 214 correlates, of which 56% had statistical significance (Dawson, 2007). However, secondary researchers should exercise care to limit the data to align the data with their research questions (Magee, Lee, Giuliano, & Munro, 2006).

NHS Staff Survey Questions Aligned With the Research Questions

Appendix B contains a list of the questions and the alignment with variables examined in this study. In general, higher scores indicated favorable working conditions. There are six questions regarding the predictor variable of organizational culture. Four of the organizational culture items measured leadership and two measured communication. A leadership question measured avoidant leadership. The scoring of the question regarding blaming/punishing employees who are involved in an error/near miss/ incident is an exception to workers preferring high scores. Jackson et al. (2013) described blaming employees for reporting errors as an exemplar of hostile avoidant leadership; therefore, a lower score on the blaming/punishing question is preferred over a higher score.

Seven questions aligned with the predictor variable of job satisfaction, Buttigieg and West (2013) attributed the job satisfaction questions to the Warr-Cook-Wall Job Satisfaction Survey. Higher scores on the Job Satisfaction Scale indicated greater levels of job satisfaction (Goetz et al., 2012). The properties of job satisfaction questions included a Cronbach's alpha of .87 with the inter-item correlations between .4 and .6 (Buttigieg & West, 2013). A battery of three questions measured the dependent variable intention to leave employment (ITL).

The NHS Staff Survey included the Intention to Quit Scale developed by Mobley, Horner, and Hollingsworth in 1978 (Buttigieg & West, 2013). Directionally, a high score on the Intention to Quit Scale reflected an increased intention to leave employment (Colarelli, 1984). In a study of full-time entry-level tellers (n = 164) employed at a bank with a 50% turnover rate, the internal consistency reliability of the Intention to Quit Scale

was .75 (Colarelli, 1984). Dawson (2007) reported a Cronbach's alpha of .85 for the intention to leave questions from the NHS Staff Survey. Researchers have drawn upon data from the NHS Staff Survey to support the examination of the study variables in combination with other constructs and to build a model of nurse's intentions regarding continued employment.

Researchers have provided empirical evidence at the trust level regarding a positive correlation between incivility and ITL (Baluch et al., 2013). Carter and Tourangeau (2012) relied on respondents to the 2009 NHS Staff Survey to test the model of determinants of nursing intention to remain employed. The model of determinants of nursing intention to remain employed aligned with organizational culture and ITL variables (Tourangeau et al., 2010). Tourangeau et al. (2010) deduced that nurses formed their ITL directly from workplace events without processing a sense of job satisfaction. Use of the NHS Staff Survey outside of the unaltered NHS Staff Survey Co-ordination Centre is emergent.

A question subset permitted research concerning the satisfaction levels of health information volunteers (Macdonald et al., 2009). Job satisfaction scores from the NHS Staff Surveys for the period between 2009 and 2012 indicated the transient changes in job satisfaction scores associated with Trust mergers (Lin, 2014). Due to the file size, the raw data is available by request. The documentation concerning obtaining the data is in Appendix D.

Data Collection Technique

I studied the data from the administration of the 2011 NHS Staff Survey. Procedurally, the data collection was via paper surveys and respondents have the option of completing the survey during their scheduled work duties (National Health Service, NHS Staff Survey Co-ordination Centre, 2011). The employer trust provided a list of potential employees to receive the survey, but copies of the survey went directly by mail to the employees (Admasachew & Dawson, 2011). To protect the anonymity of employees returned the completed surveys directly to the approved independent survey contractors (National Health Service, NHS Staff Survey Co-ordination Centre, 2011). The independent survey contractor sent follow-up requests after three weeks and after six weeks (Admasachew & Dawson, 2011) which may have contributed to the response rates.

I studied this secondary data for a number of reasons. The strengths of using the secondary data stem from access, breath, and low cost (Dunn et al., 2015). The data is archival and therefore not subject to the barriers to accessing data from hospital employees resulting for a second level of IRB approval (Secanell et al., 2014). Boo and Froelicher (2013) advocated conducting research on a national scale to improve generalizability. The 2011 NHS Staff Survey data included responses from participants at the national level (Woodrow & Guest, 2012). Secondary data might provide access to data beyond the scope available to new researchers (Boo & Froelicher, 2013). Particularly, given the low participation rates of hospital employees attributed to research subject overload (Alvarez et al., 2012). There was no financial cost for gaining access to

the data. A weakness regarding secondary data is the instruments used might differ from the preferred instrument (Greenhoot & Dowsett, 2012). For example, the NHS Staff Survey questions included intention to leave questions, which Carter and Tourangeau (2012) converted to proxy questions for intention to remain. The 2011 NHS Staff Survey is the most recent administration that included the ITL questions. As noted by Glambek et al., (2014) the time gap might limit the application of the study findings to current conditions. The next section includes a review of analysis of 2011 NHS Staff Survey data.

Data Analysis

The overarching research question based on data from a survey of U.K. acute care nurses (nurses) was: What is the relationship among nurses' job satisfaction, organizational culture, and intention to leave employment? Three sub-questions support the examination of the predictor variables and the urgency of the dependent variable intent to leave employment.

RQ 1: What is the relationship among nurses' job satisfaction, organizational culture, and a nurse thinking about leaving their employer?

RQ 2: What is the relationship among nurses' job satisfaction, organizational culture, and a nurse planning a job search within the next 12 months?

RQ 3: What is the relationship among nurses' job satisfaction, organizational culture, and a nurse planning to leave as soon as they find another job?

Correlational studies were the dominant design for examining the dependent variable intention to leave (Allen et al., 2014). Researchers used a variety of statistical

analysis for correlational ITL studies. Boone and Boone (2012) reminded academics that item level Likert-type result in ordinal scale data. In addition, Pinder et al. (2013) determined that the 2009 NHS Staff Survey data did not meet the normality assumptions required for parametric tests. Therefore, I applied a nonparametric test. The Spearman Rank Correlation Coefficient (Spearman's rho) is a special case application of the Pearson Correlation coefficient that is suitable for ordinal data (Weinberg & Abramowitz, 2002). Spearman's rho is a measures strength and direction of the relationships (Klopper et al., 2012). The following is a summary of research with a) Spearman's rho, b) Likert-type data, and c) constructs that were similar to the research questions.

The RN4CAST survey that included Likert-type question sets to measure job satisfaction, adverse events, and intention to leave was administered to critical care nurses (n= 935) in South Africa (Klopper et al., 2012). Klopper et al. (2012) used a two-tailed test ($p < .01$) and presented r_s in text and tables. In a study of supervision and job satisfaction perceptions of South African public service employees (n = 246), a two-tailed test was examined at two p values (Mafini & Dlodlo, 2014). Mafini and Dlodlo (2014) found a positive and moderate association between supervision and job satisfaction r_s (246) = .461, $p < .001$. In the United States neonatal intensive care unit workers (n = 547) completed the 65 Likert-type questions within the intensive care unit version of the Safety Attitudes Questionnaire (Profit et al., 2012). In the context of my study, Profit et al. (2012) reported an association between safety climate and working conditions r_s (547) = .92, $p < .0001$. Spearman's rho is a nonparametric alternative to the Pearson

correlation. In addition to ruling out the Pearson correlation, I also evaluated and did not accept other methods evidenced in the literature that did not align with this research.

The first alternative of logistical regression did not align with data. Archival data from the NHS Quality of Life Survey included ITL as measured by a dichotomous instrument (Deery et al., 2011). The presence of a binary dependent variable indicated analyzing the data with logistical regression (Deery et al., 2011). Blaauw et al. (2013) recoded Likert-type data that measured ITL of African nurses to binary data which resulting in the application of logistical regression. The second alternative test did not align with the purpose of the study.

The purpose of the study was to examine the relationship among nurse's job satisfaction, organizational culture, and ITL. I did not attempt to develop nor to test a complex web of mediating relationships. Therefore, it is not appropriate to use structured equation modeling (SEM). SEM has similarities with ordinary least squares regression and the supported concurrent analysis multiple hypotheses (Baluch et al., 2013). Buttigieg and West (2013) conducted SEM to examine NHS Staff Survey data regarding the relationships between leadership, and job design, and with relationships between workplace stressors that resulted in strain. SEM was an apt procedure for developing a complex model of the linkages between human resources systems and patient complaints (Baluch et al., 2013). SEM analysis was suitable for the examination of 11 predictor variables to test the Tourangeau et al. (2010) model of determinants of nurse's intention to remain employed.

With a large number of observations, missing data might be an issue (Greenhoot & Dowsett, 2012). When adjusting for missing data researchers must comply with the assumptions underlying the data and the possible rationale for missing data (Pigott, 2001). Researchers have taken different approaches to missing data from the NHS Staff Survey output. The first option was to remain silent on the issue of missing data as evidenced by Woodrow and Guest (2014). Complete case analysis, which resulted in dropping responses with incomplete data, is a common approach for regression analysis (Pigott, 2001). Complete case analysis is synonymous with listwise deletion (Pigott, 2001). Lim (2014) acknowledged missing data at a rate of 0% to 30% per question for NHS Staff Surveys completed from 2009 to 2012. Conditional imputation did not apply due to the data format and the absence of a model regarding the effects of perceptions on other perceptions (Lim, 2014). Therefore, Lim adopted a complete case analysis. Other researchers have adopted the complete case analysis method with the NHS Staff Survey data. For 2007, 86% of the nurses completed all of the NHS Staff Survey questions, which prompted removing the incomplete responses (King et al., 2012). Likewise, a completion rate of 87% for the 2009 NHS Staff Survey also resulted in removing partial responses from the database (Carter & Tourangeau, 2012). The completion rate for the questions I examined in the 2011 NHS Staff Survey was 92%. Therefore, I cleaned the missing data using the complete case method. In addition to managing the threat of missing data, it is important to recognize and address the assumptions for using Spearman's rho.

Nonparametric tests are not subject to the parametric assumptions of independence, normality, variance, and homoscedasticity (Siegel, 1957). However, observations used for nonparametric analysis must be independent (Siegel, 1957). The random sampling procedure for the NHS Staff Survey (Pinder et al., 2013; Woodrow & Guest, 2014) should produce independent observations (Weinberg & Abramowitz, 2002). Researchers used Spearman's rho to identify the directional relationship between variables using a monotonic function (Doloi, Sawhney, Iyer, & Rentala, 2012). Monotonicity includes linear and curvilinear associations in which larger values of a variable correspond to larger values of a second variable (Woods, 2009). If the variables move in the same direction, a positive monotonic relationship exists while movement in the opposite direction is a negative monotonic relationship (Woods, 2009). As demonstrated in a study of preventable deaths and safety measures at British hospitals, a scatterplot can provide a visual confirmation of monotonic relationships (Hogan, Healey, Neale, Thomson, Vincent, & Black, 2014).

I utilized IBM SPSS Statistics version 21 (SPSS) software to analyze the data. Greenhoot and Dowsett (2012) pointed out SPSS as a suitable program for the analysis of secondary data. Researchers who used SPSS software in conjunction with the NHS Staff Survey data included the following. Researchers analyzed 2008 NHS Staff Survey data at the institutional level (n = 167) using SPSS to examine the relationship between human resources systems and hospital performance metrics (Baluch et al., 2013). Carter and Tourangeau (2012) also applied SPSS to test the determinants of hospital nurses intention to remain employed with the 2009 responses of acute care nurses (n = 16,707). In a

repeated cross-sectional study, academics used SPSS in their analysis of all nurses for the 2006 NHS Staff Survey (n = 48,365) and the 2009 NHS Staff Survey (n = 55,381) concerning workplace aggression and the employees' sense of wellbeing (Woodrow & Guest, 2012).

Study Validity

Methodological quality is a prerequisite for generalizable study results (Elvik, 2012). A rigorous level of methodological quality required the researcher to address statistical conclusion validity (Elvik, 2012). Validity is a measure of truth with the recognition that observations contain elements of truth and errors (Higgins & Straub, 2006). While secondary data might result in issues regarding internal validity the large data sets might provide greater external validity (Magee et al., 2006). The use of archival research limited the threats to internal validity to statistical conclusion validity. The following segments contain my discussion of statistical conclusion validity and external validity.

Statistical Conclusion Validity

Statistical conclusion validity is a function of selecting the correct statistical analysis and confirming the data met the statistical assumptions (Higgins & Straub, 2006; Wheeler, Shanine, Leon, & Whitman, 2014). Higgins and Straub (2006) also noted that statistical conclusion validity contained the random errors due to issues with reliability. The NHS Staff Survey is a reliable instrument that advanced from existing psychometrically robust instruments (Michie & West, 2004). Woodrow and Guest (2012) stated that the NHS Staff Survey provided researchers with an array of validated

measures of workplace attitudes. Empirically, the 2007 NHS Staff Survey contained 12,214 correlates of which 56% were statistically significant (Dawson, 2007).

The data already exists in the format of responses to five-point Likert-type questions. Use of the Spearman's rho as the statistical method for examining monotonic relationships assumed independent sampling (Siegel, 1957). One approach to meeting the assumption of independent samples is conducting a random sample (Weinberg & Abramowitz, 2002). The potential participants for completing the NHS Staff Surveys were determined by random sampling (Pinder et al., 2013; Woodrow & Guest, 2014). Equally important to providing evidence regarding the reliability of the instrument and the data meets the statistical test assumptions, the sample size must have sufficient power to justify the alpha and effect sizes (Gaskin & Happell, 2014). Liu (2015) noted a trend toward the inclusion of statistical power information in the application process for research grants.

Boo and Froelicher (2013) provided suggested levels of an alpha level of .05 and a beta level of .20. The alpha level is the probability of rejecting the null that is true while the beta value is the probability of failing to reject a false null hypothesis (Boo & Froelicher, 2013). The compliment of beta, also known as the power, is the probability of correctly rejecting a false null hypothesis (Boo & Froelicher, 2013). A review of the tables provided of Cohen (1988) indicated that sample sizes over 1,000 were sufficient to attain a power level above .995 for all alpha levels and all effect sizes. For statistical analysis completed with Spearman's rho the effect size thresholds from the Cohen (1998) convention are (a) small effect size (d = .10), (b) medium effect size (d = .30), and (c)

large effect size (d = .50; Gaskin & Happell, 2014). The administration of the 2011 NHS Staff Survey established the sample size. Overall, 134,967 NHS employees completed the 2011 NHS Staff Survey. The sample size after limiting respondents to nurses employed in acute care trusts was 23,134. Cleaning the data by complete case deletion of missing data resulted in a sample size of 21,257. This was larger than the sample 16,707 from the 2009 NHS Staff Survey data used by Carter and Tourangeau (2012). Carter and Tourangeau examined ITL in the context of different questions. Therefore, the unequal sample sizes might be attributable to response rates at the question level. Given the sample size (n = 21, 257) a post-hoc analysis using the Cohen (1998) tables the indicated power values greater than .995 for all effect sizes.

In a critical analysis of articles (n= 333) regarding the appropriate use and reporting of inferential statistics in nursing research, Gaskin and Happell (2014) judged articles based on the authors disclosure of statistical power, effect size, and confidence intervals. Researchers who relied on the work by Cohen for assessing statistical power in studies similar to my examination included the following. In an empirical study regarding nursing shiftwork and nurses (n = 498) ability to remain employed the application the researchers defended statistical power and reported effect sizes based on the work by Cohen (Peters, Engels, de Rijk, & Nijhuis, 2015). Secondary researchers must confirm that their finding go beyond statistical significance and include meaningful contributions to practice (Boo & Froelicher, 2013).

External Validity

The population for the NHS Staff Survey is every health care trust in the U.K. (Woodrow& Guest, 2012); therefore, the potential external validity of the study is within the European Union and internationally. Across the globe, nursing managers were concerned with nursing turnover (Brown et al., 2013). The business implications of nursing turnover cross borders when countries have similar structures for labor costs (Hancock et al., 2011). Furthermore, researchers have extended external validity for ITL studies across the European Union (Chan et al., 2013; Hayes et al., 2012) and to countries with European cultural roots (Li & Jones, 2013; Roche et al., 2014). Blumenthal and Dixon (2012) championed U.S. U.K. cross-national learning to address issues regarding health care quality and costs.

The NHS Staff Survey is a compilation of instruments drawn from studies in the U.K. and internationally (Michie & West, 2003). Faculty in the United States developed two source instruments that aligned with the questions found in Appendix B. The Job Diagnostic Survey developed by Hackman and Oldham was the source instrument for job satisfaction measures within the NHS Staff Survey (Buttigieg & West, 2013; Michie & West, 2003). Hackman and Oldham (1975) developed the Job Diagnostic Survey in 1975 while the authors were faculty at Yale University and the University of Illinois at Urbana-Champaign. The sample for designing and validating the Job Diagnostic Survey as individuals employed in the east, the southeast, and the Midwest (Hackman & Oldham, 1975). Similarly, faculty from the University of South Carolina described their sample for developing the Intention to Quit Scale as employees of a southeastern hospital (Mobley,

Horner, & Hollingsworth, 1978). Intensive literature reviews and documentation for constructing models regarding nurse's employment intentions support extending the external validity of this study to include nurses across the European Union and countries with similar national cultures.

In a comprehensive analysis of the literature regarding nurse's intention to leave their employer or to leave the nursing profession, Chan et al. (2013) cited studies of nurses in the European Union. Examples of the participants for the works cited included Finland, Sweden, and England (Chan et al., 2013). The exhaustive synopsis of the literature regarding nurse turnover, job satisfaction, and turnover costs/outcomes completed by Hayes et al. (2012) reinforced the shared perceptions of European Union nurses and countries with national cultural ties to Europe. Works cited by Hayes et al. (2012) included nurses from the European Union member states of Belgium, Finland, Holland, The Republic of Ireland, and a study across ten European Union countries. Hayes et al. also included research regarding nurses employed in countries with national cultures with European foundations that included Australia, Canada, and the United States and New Zealand. Two 21st century conceptual models of nurse's intentions regarding employment arose from studies of nurses employed in Europe and European cultural based nations.

The literature review included both the model of determinants of hospital nurses intention to remain employed as developed by Tourangeau et al. in 2010 and the model of factors influencing nurse managers' intention to stay introduced in 2013 by Brown et al. In the context of external validity, these model developers relied on studies across nations

in the European Union and countries with similar national cultures. The foundational research for the conceptual model developed by Brown et al. came from England, Sweden, Australia, Canada, and the United States. Tourangeau et al. (2010) developed their empirical model using data from Canadian nurses. Researchers validated the Tourangeau et al. model of the determinants of hospital nurse's intention to remain employed using data from the 2007 NHS Staff Survey (Carter & Tourangeau, 2012).

Transition and Summary

Section 2 included a restatement of the purpose statement as the foundation for subsections titled (a) role of the researcher, (b) participants, (c) research methods and designs, (e) population and sampling, (f) ethical research, (g) data collection instruments, (h) data analysis, and (i) study validity. In summation, I accepted of my role as an ethical researcher who conducted an examination of the relationship between British nurse's job satisfaction, organizational culture, and intention to leave employment. The quantitative correlational study examined archival data from an instrument that academics have accepted. The extant literature supported possible generalization of the study across Europe and to countries with cultures rooted in European traditions.

Section 3 includes my presentation of the finding from the analysis of the data using SPSS. In addition, section 3 contains the applications for business and implications for social change both of which lead to recommendations for action. I also included my recommendations for further research and reflections.

Section 3: Application to Professional Practice and Implications for Change

The purpose of this quantitative, correlational study was to examine the relationship among nurse's job satisfaction, organizational culture, and ITL. This section opens with the presentation of the findings based on the responses to the 2011 NHS Staff Survey. Briefly, the Spearman rho coefficient was statistically significant ($p < .01$) for the independent variables job satisfaction and organizational culture. Evidence of statistical significance as calculated using SPSS occurred for each of the three intensity levels of the dependent variable ITL. Furthermore, the internal validity as measured by Cronbach' α exceeded .70 for each of the two predictor variable scales. This section also includes the applications to professional practice and implications for social change as informed by the findings. Section 3 also includes recommendations for action along with recommendations for future research. Furthermore, this section contains my personal reflections on the process and the study conclusions.

Presentation of the Findings

With secondary data, the researcher selects the data; the researcher does not choose the questions used to gather the data (Boo & Froelicher, 2013). The questions used to obtain data to examine the study variables were all five point Likert-type questions anchored with *strongly disagree* and *strongly agree*. For each of the predictor variables, six questions informed the response for the respective constructs.

Appendix B contains the question wording and the alignment with the study variables. Combining the six questions for the predictor variables resulted in a score for the construct with a range of 5 when a respondent selected strongly disagree for all items

to 30 when a respondent indicated strongly agree for items. Boone and Boone (2012) suggested that Likert-scale data developed from four or more Likert-type questions resulted in interval data. However, as shown in Appendix B, the questions regarding ITL remained as Likert-type measures. Therefore, the responses for ITL are ordinal. Correlations of ordinal data align with Spearman rho (Siegel, 1957). Spearman's rho was the statistical test employed to examine the hypothesized relationships among nurse's job satisfaction, organizational culture, and ITL. Spearman's rho is a nonparametric measure of correlation (Siegel, 1957). Moreover, nonparametric pairwise tests are an appropriate correlation test when the data do not meet the normality assumptions needed for a parametric correlation test (Pinder et al., 2013; Siegel, 1957). A visual examination of the histogram of the Likert-scale for job satisfaction indicated that this measure did not meet the normality assumption. Figure 1 is the histogram of the observed job satisfaction measures.

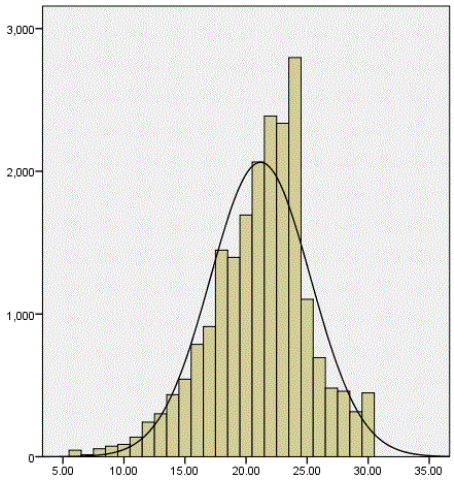

Figure 1. Histogram of job satisfaction Likert-scale with normal curve. Theoretical scale range is 6-30.

The observed frequencies in Figure 1 for the scores 23, 24, and 25 are not consistent with a normal distribution. The visual inspection of the histogram of the observed organizational culture Likert-scale found in Figure 2 revealed a normal distribution.

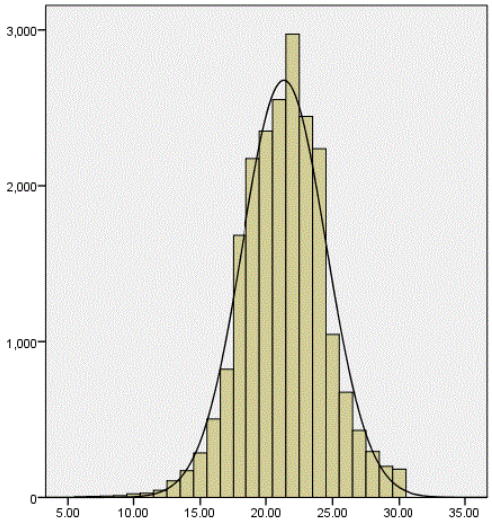

Figure 2. Histogram of organizational culture Likert-scale with normal curve. Theoretical range of scale is 6-30.

Descriptive Statistics and Statistical Assumptions

Employees across the NHS (*n* = 134,967) completed the 2011 NHS Staff Survey. Within these responses were nurses employed at acute care trusts (*n* = 23,134). Lim (2014) recommended complete case analysis for missing data in the absence of a model regarding the effects of perceptions on other perceptions Cleaning for missing data using complete case analysis resulted in the study sample (*n* = 21,257).. The completion rate for the questions examined of 92% was greater than the 86% rate for nurses who completed all questions (King et al., 2012). The 92% completion rate also exceeded the 87% completion rate for the data examined by Carter and Tourangeau (2012). To protect the anonymity of respondents, the Picker Institute Europe removed all demographic

information at the respondent level. Therefore, I could not compute the descriptive statistics for demographic variables.

The predictor variables for the hypotheses sets were job satisfaction and organizational culture. Each of the Likert-scales used in this research contained six Likert-type items on a scale of 1 to 5. The questions appear in Appendix B along with the question's alignment to the predictor variables of this research. Employees prefer working in an environment that supports higher levels of agreement for job satisfaction (Atinga et al., 2013; Heinen et al., 2013; Price & Mueller, 1981) and higher levels of agreement for organizational culture (Biron & Boon, 2013; Robson & Robson, 2015). Nevertheless, blaming an employee for errors/near misses/incidents is inconsistent with a safety culture as a component of organizational culture (Stavrianopoulos, 2012). Employees prefer working in a safety culture environment (Goh et al., 2013). To maintain consistent scoring, I reversed coded the question regarding blaming or punishing employees involved in errors/near misses/incidents.

Mean and standard deviation are appropriate descriptive statistics for a Likert scale of four or more Likert-type items (Boone & Boone, 2012). The observed range mirrored the theoretical range of responses from 6 to 30 for the measures of job satisfaction and the gauge for organization culture. As shown in Table 1 nurses who completed the 2011 NHS Staff Survey (n = 21,257), reported a mean score for job satisfaction (M = 21.8) was higher than the mean score for organizational culture (M = 21.3). In addition, the dispersion was greater for job satisfaction (SD = 4.1) than for

organizational culture (*SD* = 3.2). A nurse who took the neutral position on all questions would have a score of 18.

Table 1

Descriptive Statistics for the Likert-Scales Job Satisfaction and Organizational Culture

Variable	Minimum	Maximum	*M*	*SD*
Job satisfaction	6	30	21.18	4.110
Organizational culture	6	30	21.34	3.167

Note. n = 21,257.

With ordinal data, the mode is a proper measure of central tendency (Boone & Boone, 2012). The frequency schedule in Table 2 indicated that *disagree* produced the mode for all intensity levels of ITL. Each level of ITL had a single mode.

Table 2

Frequency Table for ITL at Each Intensity Level of ITL

Scale response	ITL-T		ITL-P		ITL-ASA	
	#	%	#	%	#	%
Strongly disagree	2,917	13.7	3,650	36.9	4,487	21.1
Disagree	6,757	31.8	7,841	36.9	8,097	38.1
Neither agree nor disagree	4,942	23.2	5,507	25.9	5,419	25.5
Agree	4,579	21.5	2,829	13.3	1,888	8.9
Strongly agree	2,062	9.7	1,430	6.7	1,366	6.4

Note. n = 21, 257, # = count of respondents, % = percentage of total sample, ITL-T = intention to leave as measured by thinking about leaving, ITL-P = intention to leave as measured by planning a job search within the next 12 months. ITL-ASA = intention to leave as measured by planning to leave as soon as they find another job.

As a nonparametric test, Spearman's rho is not subject to the assumptions of normality, variance, and homoscedasticity (Segal, 1957). The assumption of independent sampling applies to analysis with Spearman's rho (Segal, 1957). According to Weinberg and Abramowitz (2002), a random sample should produce independent sampling. The NHS Staff Survey contractors used a random sampling technique to solicit potential respondents (Pinder et al., 2013; Woodrow & Guest, 2014).

Inferential Statistical Analysis

The overarching research question was the following: What is the relationship among job satisfaction, organizational culture? Nurses' level of ITL informed three sub questions. Overall, the Spearman's rho as calculated using SPSS resulted in statistically significant correlations (p <.01) for all sub questions. However, the effect sizes of pairwise relationships as determined with Spearman's rho differed. Prior to completing the inferential statistics, I completed a post hoc analysis of the data to confirm the sample size was sufficient for the observed results. As summarized in Table 3, the findings included the most demanding combinations were significance of p < .001) and effect size of -.534. A post hoc G*Power analysis indicated an achieved power of 1. However, the Cohen (1988) tables specified a power greater than .995.The following text, figures, and tables reflect the findings from the nurses (n = 21, 257) who completed the questions in the 2011 NHS Staff Survey that aligned with this research.

Research Question 1. The first research question was as follows: What is the relationship among nurse's job satisfaction, organizational culture, and a nurse thinking about leaving their employer? I completed a series of Spearman's rho calculations to

determine if there was any relationship among nurse's job satisfaction, organizational culture, and a nurse thinking about leaving their employers (ITL-T). A two-tailed test of significance indicated there was a significant negative relationship between the nurse's job satisfaction and their ITL-T r_s (21,257) = -.534, $p < .01$. Similarly, there was significant negative relationship the nurse's self-report regarding organizational culture and their ITL-T r_s (21,257) = -.348, $p < .01$. Correlations range from -1.00 to 1.00 inclusive. For behavioral scientists, Cohen (1998) suggested that the absolute value of the correlation coefficients indicated the effect size. According to Gaskin and Happell (2014), with Spearman's rho, the appropriate thresholds for effect size are small (d = .10), medium (d = .30), and large (d =.50). Therefore, the relationship between job satisfaction and ITL-T (d = .534) was found to exceed Cohen's (1998) convention for a large effect size (d = .50). The relationship between the measure of organizational culture and ITL-T (d = .348) was found to exceed Cohen's (1998) convention for a medium effect size (d = .30).

Figure 3 is a visual representation of the three relationships. A nurse with a higher-level satisfaction had a lower level of ITL-T. Likewise, a higher level of a nurse's measure of organizational culture the lower their ITL-T. In contrast, a higher level of job satisfaction associated with a higher measure of organizational culture. The relationship between job satisfaction and organizational culture (d = .461) was found to exceed

Cohen's (1998) convention for a medium effect size (d = .30).

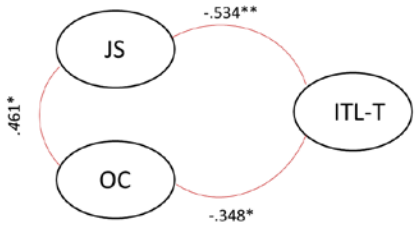

Figure 3. Correlates among job satisfactions, organizational culture, and ITL –T. r_s (21,257). JS = job satisfaction, OC = organizational culture, ITL-T = intention to leave as measured by thinking about leaving.

*p < .01 medium effect. ** p < .01 large effect.

Research Question 2. The second research question was as follows: What is the relationship among nurse's job satisfaction, organizational culture, and a nurse planning a job search within the next 12 months? I completed a series of Spearman's rho calculations to determine if there was any relationship among nurse's job satisfaction, organizational culture, and a nurse planning to leave their employer (ITL-P). A two-tailed test of significance indicated there was a significant negative relationship between the nurse's job satisfaction and their ITL-P r_s (21,257) = -.495, p < .01. Similarly, there was significant negative relationship the nurse's self-report regarding organizational culture and their ITL-P r_s (21,257) = -.321, p < .01. Therefore, the relationship between job satisfaction and ITL-P (d = .495) was found to exceed Cohen's (1998) convention for a medium effect size (d = .30). The relationship between the measure of organizational culture and ITL-P (d = .321) was found to exceed Cohen's (1998) convention for a medium effect size (d = .30). The output from SPSS of the two tailed test of significance

confirmed a significant positive relationship with medium effect size between job satisfaction and organizational culture r_s (21,257) = .461, p < .01.

Figure 4 is the exhibit of the three relationships. The higher the nurse's level of job satisfaction the lower their level of ITL-P. Likewise, a higher level of a nurse's measure of organizational culture the lower their ITL-P. In contrast, a higher level of job satisfaction associated with a higher measure of organizational culture.

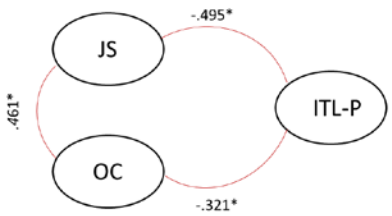

Figure 4. Spearman's rho correlates for ITL-P. r_s (21,257). JS = job satisfaction, OC = organizational culture, ITL-P = intention to leave as measured by planning a job search within the next 12 months.

*p < .01 medium effect. ** p < .01 large effect.

Research Question 3. The third research question was as follows: What is the relationship among nurse's job satisfaction, organizational culture, and a nurse planning to leave as soon as they find another job? I completed a series of Spearman's rho calculations to determine if there was any relationship among nurse's job satisfaction, organizational culture, and thinking about leaving their employers (ITL-ASA). A two-tailed test of significance indicated there was a significant negative relationship between the nurse's job satisfaction and their ITL-ASA r_s (21,257) = -.523, p < .01. Similarly,

there was significant negative relationship the nurse's self-report regarding organizational culture and their ITL-ASA r_s (21,257) = -.340, p < .01. Therefore, the relationship between job satisfaction and ITL-ASA (d = .523) was found to exceed Cohen's (1998) convention for a large effect size (d = .50). The relationship between the measure of organizational culture and ITL-ASA (d = .340) was found to exceed Cohen's (1998) convention for a medium effect size (d = .30). The output from SPSS of the two tailed test of significance confirmed a significant positive relationship with medium effect size between job satisfaction and measure of organizational culture r_s (21,257) = .461, p < .01.

Figure 5 is the exhibit of the three relationships. The higher the nurse's level of job satisfaction the lower their level of ITL-ASA. Likewise, a higher level of a nurse's measure of organizational culture the lower their ITL-ASA. In contrast, a higher level of job satisfaction associated with a higher measure of organizational culture.

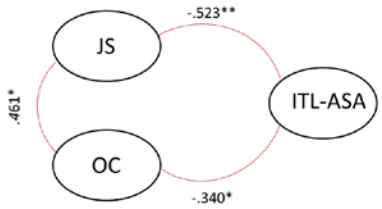

Figure 5. Spearman's rho correlates for ITL-ASA r_s (21,257). JS = job satisfaction, OC = organizational culture, ITL-ASA = intention to leave as measured by planning to leave as soon as they find another job.

*p < .01 medium effect. ** p < .01 large effect.

I confirmed the internal consistency of Likert-scales for job satisfaction and organizational culture with Cronbach's α. Cronbach's α is a measure of the relationships of item consistency (Institute of Digital Research and Education UCLA. 2015). The

higher the Cronbach's α the greater the internal consistency, in social science research a benchmark is (α = .70; Institute of Digital Research and Education UCLA. 2015). The job satisfaction scale consisted of six items (α = .817). This result was similar to the job satisfaction scale (α = .87) across NHS Staff Surveys conducted between 2004 and 2010 (Buttigieg & West, 2013). The organizational culture scale consisted of six items (α = .726). This result is consistent the job design finding (α = .73) calculated by Buttigieg and West.

Summary of Research Question Statistics and Relation to the Hypotheses.

As summarized in Table 3 a series of Spearman's rho correlations conducted using SPSS indicated significant relationships among the job satisfaction, organizational culture, and ITL. The effect sizes according Cohen's convention (1988) were medium or large.

Table 3

Correlations Among Job Satisfaction, Organizational Culture, and ITL

Variable	ITL-T	ITL-P	ITL-ASA
Job satisfaction	-.534**	-.495*	.523**
Organizational culture	-.345*	-.321*	-.340*

Note. ITL-T = intention to leave as measured by thinking of leaving; ITL-P = intention to leave as measured by planning a job search within 12 months; ITL-ASA = intention to leave as planning to leaves as soon as finding another job.

* r_s (21,257) 2-tailed was statically significant at $p < .01$ with medium effect size; ** r_s (21,257) 2-tailed was statically significant at $p < .01$ with large effect size.

Therefore, I reject the null hypothesis for each intensity level of ITL. I reject $H1_0$, that there is no significant relationship among nurses' job satisfaction, organizational culture, and a nurse thinking about leaving their employer. I also reject $H2_0$, that there is

no significant relationship among nurses' job satisfaction, organizational culture, and a nurse planning a job search within the next 12 months. Finally, I reject $H3_{0,}$ that there is no significant relationship among nurse's job satisfaction, organizational culture, and a nurse planning to leave as soon as they find another job.

Alignment with the theoretical framework and other literature. The theoretical framework of the reasoned action as proposed by Ajzen and Fishbein in 1975 with modifications in 1980 is a model for evaluating complex decisions (Prestholdt et al., 1987). The formation of the intention to leave employment is a complex decision (Brewer et al., 2012). In the 21st century, reasoned action theory provided theoretical support for two conceptual models of nurse's employment intentions. These are the proximal withdrawal model (Hom et al., 2012) and the model of the determinants of hospital nurses intention to remain employed (Tourangeau et al., 2010).

The findings confirmed that employees might have engaged in complex decision making as reflected by the different Spearman's rho values summarized in Table 3. The relative values of job satisfaction and organizational culture differed for survey responses given the intensity level of ITL. This might indicate that nurses do not form a uniform level of ITL across the intensity levels; instead, nurses may have engaged in careful consideration of their attitudes toward their jobs before reaching a decision regarding their ITL level. That nurses might develop a particular level of ITL intensity after considering of multiple factors is also consistent with the frequency distributions for the three ITL levels. For example, the cumulative percentage of nurses who selected for agree and strongly agree with ITL-T, ITL-P, and ITL-ASA were 31.2 %, 20.0%, and 15.3

% respectively. These results from the 2011 NHS Staff were lower than the 44% of British nurses (*n* = 2,918) with ITL-T from the 2010 survey conducted by Aiken et al. (2012). The summary of respondents who expressed a level of agreement with the three intensity levels of ITL is in Table 4.

Table 4

Summary of Nurses Who Agree or Strongly Agree With ITL at Each Intensity Level of ITL

Scale response	ITL-T		ITL-P		ITL-ASA	
	no.	%	no.	%	no.	%
Agree	4,579	21.5	2,829	13.3	1,888	8.9
Strongly agree	2,062	9.7	1,430	6.7	1,366	6.4
Cumulative	6,641	31.2	4,259	20.0	3,254	15.3

Note. *n* = 21, 257, ITL-T = intention to leave as measured by thinking about leaving, ITL-P = intention to leave as measured by planning a job search within the next 12 months. ITL-ASA = intention to leave as measured by planning to leave as soon as they find another job.

The 2011 NHS Staff Survey did not include questions regarding employment options. Perhaps some of the nurses who indicated they strongly agreed to ITL-did not strongly agree with ITL-ASA in recognition that changing employers was not an option. This situation might reveal trapped stayers as posited by the withdrawal states model (Hom et al., 2012). The model of the determinants of hospital nurses intention to remain employed built on the reasoned action theory with the identification of thematic categories that nurses considered while forming their employment intentions (Tourangeau et al., 2010).

The relationship among organizational culture and ITL aligned with the determinants of hospital nurses intention to remain employed (Carter & Tourangeau, 2012). As summarized in Appendix B the organizational culture measures included questions aligned with leadership, harassment, and safety culture. The significant negative relationship among organizational culture is consistent with the findings of Carter and Tourangeau regarding conditions of the work environment. The negative relationship among the elements of organizational culture and ITL is congruent with the relationship between supportive leadership and ITL (Biron & Boon, 2013; Han & Jekel, 2011; & Kang et al., 2011). That nurses who perceived a work environment that included the adoption of a safety culture held lower ITL is consistent with the literature for Belgian nurses (Heinen et al., 2013). The results of this study also support the statistically significant negative relationship ($p < .05$) existed between safety culture and turnover rates for intensive care unit nurses (Vogus, Cooil, Sitterding, & Everett, 2014).

The positive relationship observed between job satisfaction and organizational culture ($p < .01$) is supportive of the extant literature. Price and Mueller (1981) suggested that job satisfaction was an intervening variable between dimensions of the job and ITL. Brown et al. (2013) postulated that job satisfaction was the common factor between the domains of organizational factors such as culture, role factors such as span of control, and personal factors such as feeling valued.

The importance of employment intentions research stems from the consequences of behavior surrounding ITL (Hausknecht & Trevor, 2011). The statistically significant relationships among nurse's job satisfaction, organizational culture, and ITL are the

foundations for applications and recommendations for action. In the next two subsections, I develop the applications to professional practice and implications for social change.

Applications to Professional Practice

As noted by Hausknecht and Trevor (2011) the importance of turnover research stems from the consequences of behavior regarding ITL. Investing in programs that manage ITL might benefit professional practice by managing costs and promote social change as evidenced by an improved quality of care (Tomblin Murphy et al., 2012). There are two avenues for application of these findings of significant relationships among nurse's job satisfaction, organizational culture, and ITL for professional practice. The first is the direct increases in labor expenses. The second avenue is increased expenses that arise from the secondary consequences of ITL.

Direct Consequence From Labor Expenses

Failure to manage the variables examined might lead to increased labor expenses. As shown in Table 3 a statistically significant negative relationship existed among job satisfaction, organizational culture, and ITL. Therefore, efforts to improve the survey scores for job satisfaction and/or organizational culture might reduce ITL. Likewise, failure to manage job satisfaction and/or organization culture may increase ITL thereby increasing labor expenses. I will present the increased labor costs associated with increased ITL followed by the increased labor costs associated with undesirable attributes of organizational culture.

Turnover occurs when an employee develops an ITL and the employee has alternative employment options (Hom et al., 2012). ITL is the leading precursor of turnover (Price & Mueller, 1981). When employees with ITL have alternative employment opportunities, the employee might leave their employer (Hom et al., 2012). Managing turnover costs is an established benefit of managing ITL (Hayes et al., 2012; Li & Jones, 2013). Increased costs due to nursing turnover include costs to hire the replacement, cost to train the replacement, payments for temporary replacements/overtime, and lost productivity during onboarding (Hayes et al., 2012). The lost productivity might comprise 15% of total turnover costs (Roche et al., 2014). Roche et al. (2014) used the Nursing Turnover Costs Calculation Methodology (NTCCM) with archival records from Australian hospitals (n = 11). The NTCCM included direct costs such as (a) advertising/training, (b) vacancy costs, and (c) hiring costs (Roche et al., 2014). Indirect costs within the NTCCM included (a) orientation/training, (b) decreased productivity of the inbound nurse and decreased productivity of the outbound nurse, and (c) termination costs (Roche et al., 2014). The indirect costs comprised just over half of the total turnover costs within the NTCCM (Roche et al., 2014). Roche et al. calculated the cost of replacing an Australian hospital nurse in the ranged from $17,728 to $104,686 (in U.S. dollars approximately $12,830 to $75,770). Labor costs might also increase after an employee develops an ITL and the employee remains with their employer.

As employees form their ITL, the employee might increase their work avoidance behaviors (WAB) as manifested with greater absenteeism and reporting to work late (Hom et al., 2012). Walker and Bamford (2011) indicated that if NHS managers

succeeded in reducing the absenteeism rate by 1%, they might have £34.2 million (approximately $52 million U.S.) available each year for other expenses. Walker and Bamford reported that 65.9% of managers attributed absenteeism to causes other than sickness. Furthermore, 36.6% of managers indicated that the absent staff actually did wish to work (Walker & Bamford, 2011).

The research confirmed a relationship between organizational culture and ITL. The extant literature included incentives for managing organizational culture irrespective of ITL. The secondary benefits of managing organizational culture are incentives that might help justify change initiatives with a primary focus of addressing ITL.

In addition to absenteeism and reporting late for assignments employees, miss work due to illness. While the employee misses work due to illness the employer incurs increased labor costs driven by temporary staffing/overtime costs. Managers who control workplace harassment have a prospect to mitigate the duration of illnesses. Exposure to harassment in the workplace increased the risk of an employee having a long-term absence due to illness by 92% (Ortega et al., 2011). In addition to increased expenses, the indirect consequences ITL and organizational culture can imperil profitability by way of lost revenue.

Indirect Consequence From Workplace Behaviors

Reasoned action theory posited that control over the process is required before individuals can act on their intentions (Ajzen & Fishbein, 1980). Hom et al. (2012) indicated that when an employee has ITL that they cannot act upon that employee might

exhibit counterproductive work behaviors (CWB) and (WAB). Both CWB and WAB might indirectly result in financial consequences from decreased revenue.

Diminished quality of care might reduce reimbursement for services rendered and limit the ability of a hospital to compete for additional revenue. Under the pay for performance funding system NHS hospitals experience decreased revenue for completed procedures when the quality of care results do not meet the national standards (Sutton et al.; 2012). Meanwhile high levels of quality care facilitate competition for revenue associated with caring for patients from other NHS hospitals and international patients (Lunt et al., 2013; Victoor et al., 2012). Therefore, managing CWB, WAB, and ITL might allow managers avoid financial penalties due to poor performance. Controlling CWB, WAB, and ITL may also lead to generating revenue from patients outside of their geographic area.

WAB included absenteeism and arriving for work late (Hom et al. 2012). When nurses reported late for their assignments the consequences included diminished teamwork (Klotz & Buckley, 2013) which in turn put at risk the transfer of information required for quality care (Effken et al., 2011, Estryn-Behar et al., 2014). Additionally, trapped stayers exhibited CWB such as avoiding work duties and harassing fellow employees, (Hom et al., 2012). Hiding knowledge or otherwise withholding information as a form of harassment (Connelly, Zweig, Webster, & Trougakos, 2012). Communication failures are a persistent source of medical errors notably medical errors that qualify for financial penalties (Starmer et al., 2014). Starmer et al. noted that addressing the underlying causes of miscommunication might provide cost-effective

solutions to reduce medical errors. Applications of the findings of this study also provide opportunities for positive social change.

Implications for Social Change

Completing research with an element of positive social change is a fundamental part of obtaining a Walden University Doctorate of Business Administration (Salter, 2013). The statistically significant relationship among job satisfaction, organizational culture, and ITL might provide managers with ways to promote social change for hospital stakeholders. The study findings support opportunities for social change for patients and nurses. By extension, the positive social change might also touch the family/friends of these stakeholders.

Applying the study findings to control ITL and the antecedent toxic behaviors of CWB and WAB might improve the quality of patient care. Communication is critical for preventing medical errors (Brunetto et al., 2013; Starmer et al., 2014). Pediatric patients are especially subject to medication errors stemming from incomplete communication (Blake et al., 2013). In the context of CWB, communication errors might be purposeful harassment (Connelly et al., 2012). Employees who were targets of CWB had trouble with concentrating on their jobs, which resulted in lapses in quality of care (Gallagher, 2012). Likewise, actions that reduce WAB might improve the quality of patient care. Hom et al. (2012) listed reporting late for work as a WAB. When nurses reported late for their shifts, teamwork suffered (Klotz & Buckley, 2013). Diminished teamwork put at risk the transfer of information required for quality care (Effken et al., 2011, Estryn-Behar et al., 2014).

Efforts to improve organizational culture might reduce ITL and have the added benefit of improving quality of care. Deficiencies in the organizational culture contributed to the deaths of pediatric patients at the Bristol Royal Infirmary (Pope & Burnes, 2013). Conversely, managers who supported a safety culture as evidenced by (a) encouraging employees to report errors/near misses, (b) organizational learning, and (c) a non-punitive response to reporting errors/near misses might improve the quality of care (Ghormley, 2015; Pope & Burnes, 2013). Newdick and Danbury (2013) encouraged researchers to examine organizational culture as a path to improve the outcomes of care provided by NHS Trusts. Removing the undesirable effects of CWB, WAB, and ITL is also a potential method for improving nurses' quality of life.

Bullying is a CWB that might occur after forming an ITL (Hom et al., 2012). Nurses subjected to bullying reported diminished quality of life to the point of some nurses indicating their lives were similar to individuals with post-traumatic stress disorder (Wilson et al., 2011).

Another example of CWB was hiding knowledge or otherwise withholding information (Connelly et al., 2012). Nurses had greater sensitivity to harassment from colleagues than from aggressive acts by patients (Farrell & Shafiei, 2012). Victims of workplace harassment have described symptoms analogous to post traumatic stress disorder including suicidal thoughts (Wilson et al., 2011). Management's response to bullying is critical for a nurse's quality of life. Supportive managers empowered their nurses, which encourage these nurses to put forward extra efforts to ensure quality care (Laschinger et al., 2014). An example of WAB is absenteeism (Hom et al., 2012). When

a nurse does not report for a scheduled shift, another nurse must cover the position. Filling the open shift might result in heavy workloads that could interfere with the work life balance of the replacement nurses (Boamah & Laschinger, 2015; Lu et al., 2012). CWB may also contribute to nurses missing work. Ortega et al. (2011) found that nurses who experienced CWB required 92% more time to return from leaves related to illnesses. Similar to absenteeism extended leaves due to illness required another nurse to cover the shifts.

Recommendations for Action

This subsection includes the recommendations that flow from the research and I outline steps to move the research into action. Comments regarding the stakeholders who might benefit from these finding are in this subsection. The subsection ends with potential opportunities to disseminate the information.

Professional doctorates should develop research that is actionable (Banerjee & Morley, 2013). Markides (2011) described actionable recommendations as a method for bridging the gap between academics and practitioners. Changing the culture of health care has lagged at the NHS (Chassin, 2013) and in the U.S. (Ghormley, 2015). I recommend that managers consider the job attributes that informed the Likert-type questions examined in this study. Each question contained a key phrase that offered an opportunity to change the work environment. Moving employees from the levels of disagreement might reduce ITL and the negative consequences that ensue when employees form an ITL.

The study examined Likert-scales each of which had six Likert-type questions. Subject to reverse coding for one question, a higher score reflected a work environment with a lower expected level of ITL. That is a score of 30 represented strong agreement while a score of 6 signaled strong disagreement. Given the significant negative relationship among job satisfaction, organizational culture, and ITL managers should seek higher scores to mitigate ITL.

Management could conduct surveys to determine which questions produced the lowest scores and consider changes to address those deficiencies. As an exemplar, if the question regarding the amount of responsibility given to nurses produced a low score managers might think through ways to increase the responsibility given to nurses. As noted by Chen et al. (2011) ITL is dynamic, a move from strongly agree to agree on an ITL scale might result in a sense of improvement with the employee remaining to determine if the improvements are lasting.

Regulators and accreditation boards who address patient care might benefit from changes informed by the study. Application of United States United Kingdom cross-national learning to address issues regarding health care quality and costs is consistent with the recommendations by Blumenthal and Dixon (2012). In terms of transparency, the system in the United Kingdom appears more transparent than the United States system. Annually U.S. nurses participate in surveys sponsored by trade groups and accreditation boards. However, the granular responses are not available for researchers or consumers. I recommend that regulators and accreditation boards in the U.S. consider an information system with increased transparency.

I intend to share the results of this study with my Enterprise Risk Management (ERM) students and with my consulting clients. I will also relay the information regarding the statistical analysis in my Principles of Statistics course. I intend to submit a proposal to share the results at the 2016 education forum of my regional chapter of the American Society of Healthcare Risk Management (ASHRM).

The study findings align with ASHRM ERM model. The ASHRM ERM model includes risk domains that provide a method to organize risks into manageable groups (Carroll et al., 2014). Evaluating risks through the lens of domains provides a more comprehensive picture compared to a silo view (Carroll et al., 2014). Mintzberg (2012) described hospital management structures as pigeon holed while others noted management silos (Cleven, Winter, Wortmann, & Mettler, 2014). The ASHRM ERM risk domains support evaluating the potential payback for an initiative across the domains. I expect to work with professional/academic colleagues to pursue publishing the study findings as aligned with the ASHRM ERM model. I will also provide an executive summary of the study to the representatives of the Picker Institute Europe.

Recommendations for Further Research

Secondary researchers must work with the existing data (Greenhoot & Dowsett, 2012). The efforts to protect the anonymity of 2011 NHS Staff Survey data did not support examining the relationships controlling for demographic variables. A subsequent study that included the questions used in this study in addition to the demographic questions might help to test the moderations found in the extant literature. Specifically, a

future study might examine the potential role of age, length of employment, and marital status as noted by Chiang and Chang (2012).

The 2011 NHS Staff Survey included the occupation codes. The research regarding pharmacists ITL is nascent (Mak et al., 2013). A literature search for ITL among administrative/clerical staff indicated no current research. The secondary data supports a further study to examine the relationships among the study variables across occupation codes.

Allen et al. (2014) suggested that qualitative studies of ITL might provide a deeper understanding of the turnover process. Table 4 contained a summary of the nurses with the greatest levels of ITL. Identification of the Trusts represented within Table 4 might identify sites for qualitative studies.

There might be an opportunity to review a natural experiment using NHS Staff Trust data. Edmonstone (2013a) documented a series of NHS management development programs. Researchers have access to the NHS Staff Survey data from 2003 to 2014 inclusive. If the transparency for the management development programs supports the identification of management initiatives, the archival data might support a natural experiment design.

Reflections

My objective for completing this correlational study was to examine an established topic of international concern while enhancing my proficiency as a quantitative researcher. Researchers should consider the perspective of practitioners and produce research that practitioners can apply (Markides, 2011). Given the use of archival

data, I did not interact with study participants. Therefore, I could not introduce bias into the participant's responses. However, I am cognizant of introducing potential personal bias while selecting of the study variables. As a practitioner experienced in healthcare safety I entered this research with preconceptions.

To mitigate potential bias from variable selection, I amended the predictor variables and a dependent variable as I became familiar with the NHS Staff Survey and the existing literature that aligned with the study variables. This approach was consistent with the suggestion by Greenhoot and Dowsett (2012) that secondary researchers exercise care to avoid the study of interesting variables that do not have theoretical foundations. Michie and West (2004) described the development of the NHS Staff Survey in terms of constructing an integrated framework of managerial and psychological methodologies. Accordingly, the NHS Staff Survey data has supported the examination of numerous managerial research topics. The temptation to examine tangential variables continued throughout the research process. Completing this research changed my view of lengthy surveys and large samples.

As I immersed myself in the NHS Staff Survey data available via the internet, I was concerned with the potential effects of missing data. While Jones et al. (2013) commented on the consistent response rates across NHS Staff Survey questions, Lim (2014) reported missing data rates up to 30%. A usual approach for correlational studies is to remove cases with missing responses in a complete case analysis (Pigott, 2001). Having manipulated large databases with Excel, I budgeted an extended period for

cleaning data. The conditional statement sorts within SPSS facilitated cleaning the missing cases with complete case analysis.

Summary and Study Conclusions

ITL is the leading antecedent of turnover (Price & Mueller, 1981). Perkins (1939) indicated that turnover was the second most critical measure for evaluating a hospital's nursing service. Yet in 2011, 31.2 % of the NHS nurse's surveyed indicated they had formed an ITL. This study resulted in empirical support for theory and current research regarding job satisfaction, organizational culture, and ITL. Consistent with existing knowledge a significant negative relationship existed between job satisfaction and ITL. The significant negative relationship between organizational culture and ITL was similarly consistent with the extant literature. The instruments used to measure the constructs of job satisfaction and organizational culture might provide managers with a tool to identify the areas where employees found deficiencies. Addressing these deficits may reduce ITL. Managers could apply the study results to address ITL that leads to turnover and the resultant costs of up to $104,686 Australian (approximately $75,700 U.S.) to replace each nurse (Roche et al., 2014). At the same time, efforts to reduce ITL might reduce the intervening increase in absenteeism as nurses form their ITL. Walker and Bamford (2011) suggested that a one percent reduction in the absenteeism rate at the NHS might free up £34.2 million for other uses (approximately $52 million U.S.). In addition to the possible financial benefits, managing the study variables might promote positive social change. In particular, reducing ITL by management actions to increase job

satisfaction and organizational culture might improve the quality of care for patients and improve the quality of life for nurses.

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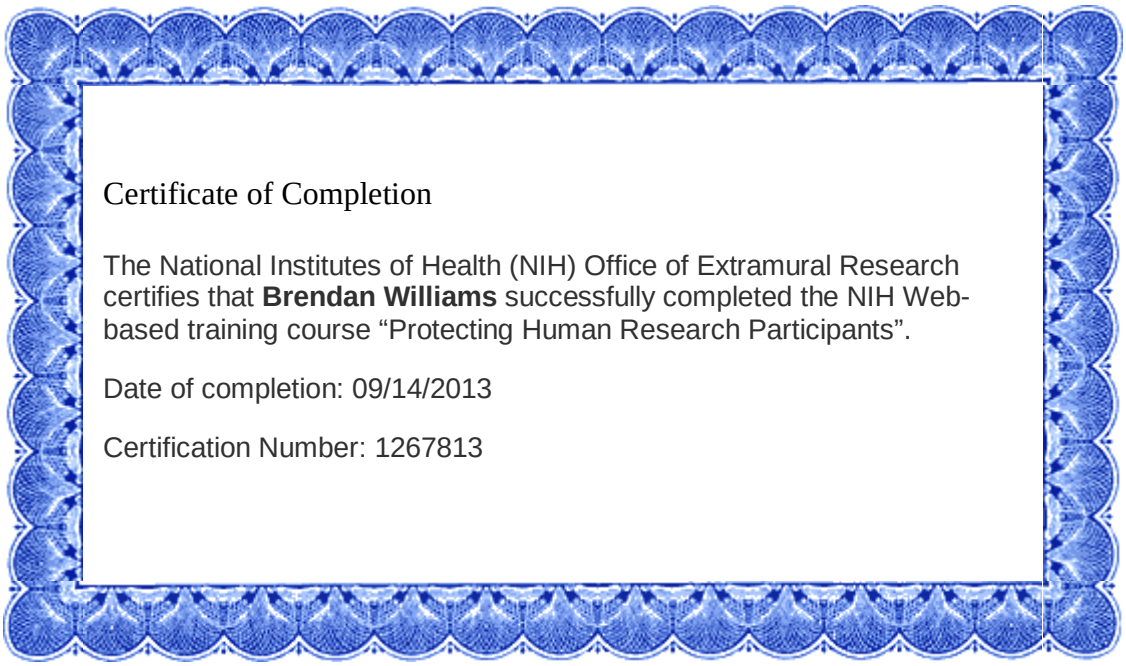
OGL

Appendix B: NHS Staff Survey Questions That Align With the StudyVariables

NHS Staff Survey	Variable alignment
My trust takes effective action if staff are bullied, harassed or abused by patients/service users, their relatives or other members of the public.	Organizational culture harassment
My trust treats staff who are involved in an error, near miss or incident fairly.	Organizational culture leadership
My trust encourages us to report errors, near misses, or incidents.	Organizational culture safety culture
My trust blames or punishes people who are involved in errors, near misses, or incidents.	Organizational culture leadership reverse coded
When errors, near misses, or incidents are reported, my trust takes action to ensure that they do not happen again.	Organizational culture leadership
We are given feedback about changes made in response to reported errors, near misses, and incidents.	Organizational culture safety culture
How satisfied are you with the support you get from your manager?	Job satisfaction
How satisfied are you with the freedom to choose your own method of working?	Job satisfaction
How satisfied are you with the support you get from work colleagues?	Job satisfaction
How satisfied are you with the opportunities to you have to use your abilities?	Job satisfaction
How satisfied are you with the amount of responsibility you are given?	Job satisfaction
How satisfied are you with the extent to which your employer values your work?	Job satisfaction
I often think about leaving this trust.	Intention to leave
I will probably look for a job at new organization in the next 12 months.	Intention to leave
As soon as I can find another job, I will leave this Trust.	Intention to leave

Note. NHS Staff Survey question from Care Quality Commission and Picker Institute Europe. (2013). *National Health Service National Staff Survey, 2011*. Reprinted under open license

Appendix C: National Institutes of Health Certificate



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Brendan Williams** successfully completed the NIH Web-based training course “Protecting Human Research Participants”.

Date of completion: 09/14/2013

Certification Number: 1267813